Medical Assistance Provider Incentive Repository

User Guide

For
Eligible Professionals

Document Control

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References

Document	Author	Date	Version
MAPIR Detailed Requirements and Specifications Document	HP	2/5/2011	2.0
MAPIR Technical Specifications – Release A	HP	3/2/2011	1.1

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Introduction to Connecticut Medicaid EHR Incentive Program

The American Recovery and Re-investment Act of 2009 was enacted on February 17, 2009. This act provides for incentive payments to Eligible Professionals (EP), Eligible Hospitals (EH), and Critical Access Hospitals to promote the adoption and meaningful use of interoperable health information technology and qualified electronic health records (EHR).

Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medical Assistance EHR incentive payments, making payments, and monitoring payments. The Medical Assistance Provider Incentive Repository (MAPIR) is a Web-based program administered by the CT Department of Social Services (DSS) that allows Eligible Professionals and Eligible Hospitals to apply for incentive payments. The incentive payments are not a reimbursement, but are an incentive intended to encourage adoption and meaningful use of EHRs.

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing the provisions of the Medicare and Medicaid EHR incentive programs. CMS issued the Final Rule on the Medicaid EHR Incentive Program on July 28, 2010:

http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf

For more information on CMS EHR requirements, link to CMS FAQ's at:
https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage

Purpose of the Eligible Provider User Guide

The Connecticut Medical Assistance EHR Incentive Program Eligible Professional Provider Manual is a resource for healthcare professionals who wish to learn more about the Connecticut Medical Assistance EHR Incentive Program including detailed information and resources on eligibility and attestation criteria, as well as instructions on how to apply for incentive payments. The Eligible Professional Provider Manual also provides information on how to apply to the program via the Medical Assistance Provider Incentive Repository (MAPIR), which is the Department's web-based EHR Incentive Program application system. The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this Provider Manual in its entirety, prior to starting the application process. In the event this provider manual does not answer your questions or you are unable to navigate MAPIR or complete the registration and application process, you should contact the EHR Assistance Center either by email at ctmedicaid-ehr@hp.com or by phone at 1-855-313-6638.

Other Resources

There are a number of resources available to assist providers with the Connecticut Medical Assistance EHR Incentive Program application process. These resources can be found at: www.ctdssmap.com, under Provider, EHR Incentive Program. For example, there are Important Messages that are frequently posted to the site to keep providers updated, and frequently asked questions.

Who is eligible?

The CMS Final Rule outlines the following mandatory criteria for an Eligible Provider (EP) to be considered for the Connecticut Medical Assistance EHR Incentive Program.

The Department also requires that EPs be enrolled as a Connecticut Medical Assistance Program provider without sanctions or exclusions. Providers that are not enrolled will need to enroll with Connecticut Medical Assistance Program prior to applying for the Department's EHR Incentive Program and must meet program requirements, including meeting Medical Assistance patient volume thresholds. Providers can

enroll in the Connecticut Medical Assistance Program by filling out an online application by going to www.ctdssmap.com and clicking on "Provider Enrollment" under "Provider". Per the final federal rule, Eligible Professionals under the Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a Federally Qualified Health Center or Rural Health Center that is so led by a physician assistant*

So led is defined by CMS to mean the following:

- When a physician assistant is the primary provider in an FQHC/RHC;
- When a physician assistant is a clinical or medical director at a clinical site of practice
- at an FQHC/RHC; or,
- When a physician assistant is an owner of an FQHC/RHC.

* The Department of Social Services (DSS) has determined that there are no FQHC/RHCs in Connecticut that are led by a physician assistant. Therefore, physician assistants are not an eligible provider type for Connecticut's EHR Incentive Payment Program.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an Eligible Professional must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume, and is a pediatrician
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

For the purposes of the Connecticut Medical Assistance EHR Incentive Program, a pediatrician is defined as a licensed physician engaged in practice where 90 percent of the practice is comprised of patients age 18 and under, and who:

- Holds board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;
- in the opinion of the department has training and or experience comparable to that required for board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;
- holds board certification by the American Board of Medical Specialties in a recognized specialty and serves a pediatric patient population; or
- in the opinion of the department provides what is generally accepted to be specialty care to a pediatric patient population.

Overview of the EHR Incentive Program Process

The following steps describe the Connecticut Medical Assistance EHR Incentive Program application process:

1. Applicants must register with the Centers for Medicare & Medicaid Services (CMS) at the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (also known as the R&A) website

https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

Applicants will need to provide information such as:

- Individual and Payee NPI and Tax Identification Number (TIN);
- Incentive Program option of Medicare or Connecticut Medical Assistance (referred to as Medicaid in the R&A),
- CMS EHR Certification Number; and,
- Email contact information.

Once successful R&A registration is completed, no changes will need to be made at the CMS R&A in subsequent years, unless there is a change in TIN or NPI Numbers due to a change in the Payee receiving the incentive payment.

2. Once successfully registered with the R&A, eligible applicants will receive a Welcome letter via email stating that they can register in MAPIR, which is accessed through the provider secure portal at www.ctdssmap.com. This may take up to two business days following successful registration with the R&A. MAPIR is the Department's Web-based system that will track and act as a repository for information related to applications, attestations, payments, appeals, oversight functions, and interface with R&A. You will be able to track the status of your application through the MAPIR system and should not go through the CMS R&A system to verify application status.

3. Applicants will use their secure provider internet portal User ID and password to access MAPIR from the Department's Web site www.ctdssmap.com. If they are an eligible professional type then a MAPIR application link will be displayed. By clicking on the link, the MAPIR application will search for a registration record received from the R&A. Once a match is found, the application process can begin. If an application is not found within three days after an applicant registered with the R&A, or if you need an ID and password to create your secure Provider account, please contact the EHR Assistance Center either by email at ctmedicaid-ehr@hp.com or by phone at 1-855-313-6638.

Applicants will need to verify the information displayed in MAPIR, enter additional required data elements, and make attestations about the accuracy of data elements entered in MAPIR. Applicants will need to demonstrate they meet:

- Medicaid patient volume thresholds;
- They are adopting, implementing, or upgrading (meaningfully using in future years) federally-certified EHR systems in the first payment year and meaningfully using the EHR systems in future years; and,
- They meet all other federal program requirements.

4. The Department will review applications submitted in MAPIR and make approval decisions. The Department will inform all applicants whether they have been approved or denied via email. All approvals and denials are based on federal rules about the EHR Incentive Program.

- Payments will be issued via the regular Connecticut Medical Assistance Program financial payment cycle that runs twice a month. Applicants will see approved payments on their remittance advices and their annual 1099's.
- It is possible the Department may need to contact applicants during the application process before a decision can be made to approve or deny an application. Applicants are encouraged to contact the EHR Assistance Center if they have questions about the process, by email at: ctmedicaid-ehr@hp.com or by phone at 1-855-313-6638.

- Applicants have appeal rights available to them; for example, if an applicant is denied an EHR incentive payment. The Department will convey information on the appeals process to all applicants denied. Appeals will be processed by the Department's Bureau of Hearings and Appeals.
- Applicants are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the applicant's covered professional services.

Application Readiness for Providers

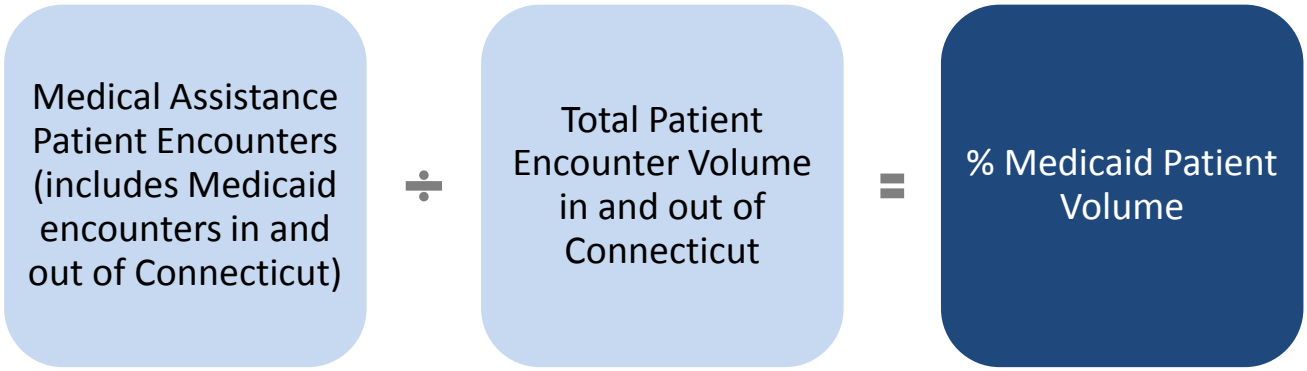
Applicants can take a number of steps to expedite the processing of their applications:

- Applicants must provide a valid email address during the CMS registration process so that the Department can inform them, by email, that their registration has been received from CMS and that they can begin the MAPIR application process;
- Applicants must obtain a Connecticut Medical Assistance provider Internet Portal User ID and password for the www.ctdssmap.com provider portal if they do not already have one.
- The NPI and TIN provided to CMS must match the NPI and Payee TIN information within the Connecticut MMIS system. This combination should be the same NPI/TIN combination that is used for Medical Assistance claim payment purposes.
- Obtain the CMS EHR Certification ID for your Electronic Health Records System from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) Web site (http://onc-chpl.force.com/ehrcert).

Patient Volume Calculation

In order to be eligible for the Connecticut Medical Assistance EHR Incentive Program, EPs must meet eligible patient volume thresholds. The basic formula for calculating the Medicaid Patient Volume is illustrated below:

Figure 1: Patient Volume Formula


Medical Assistance Patient Encounters (includes Medicaid encounters in and out of Connecticut)
÷
Total Patient Encounter Volume in and out of Connecticut
=
% Medicaid Patient Volume

EPs must meet annual patient volume thresholds. The general rule is that EPs must meet the Medicaid patient volume thresholds which is typically a minimum of 30 percent but can be 20 percent or higher for pediatricians. Medicaid patient volume is measured over a continuous 90-day period either **in the previous calendar year** or the twelve months preceding the attestation date. Providers only enter the start date and MAPIR will calculate the end date.

DEFINITION OF ENCOUNTER

A Medicaid encounter is defined as any services that are rendered on any one day to an individual enrolled in an eligible Medicaid program. There is no minimum number of patient encounters. Patient volume calculations can include managed care encounters and dual Medicaid/Medicare eligible encounters.

Note: HUSKY B patients in Connecticut are a part of a separate Children's Health Insurance Program (CHIP) and do not count toward the Medicaid patient volume, although they do count toward the needy individuals patient volume.

Exceptions:

EPs that practice predominantly at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria, (see **Figure 2** below for additional details). Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20 percent instead of 30 percent). If pediatricians have greater than 20 percent but less than a 30 percent eligible patient volume, their annual incentive cap is reduced to 2/3. Pediatricians who achieve 30 percent eligible patient volume are eligible to receive the full incentive amount for which they qualify.

Figure 2: Patient Volume Thresholds per the CMS Final Rule

Provider Type	Requirements	Threshold
Eligible Professionals		
EPs Applying as Individuals	Can use encounters from multiple locations. MAPIR will provide information for each location with Medicaid claims or provider enrollment data.	30%
EPs Applying as a Group	***Numerator:*** Includes totals for the entire group. Will require use of the group NPI(s) for verification. The group volume is then applied to all individual providers in the group. The payments are for the individual providers, thus when the group volume calculation is used, it must be applied for all individual providers in the group.	30%
Pediatrician	Must be a physician who is either board-certified as a pediatrician or has received 12 months of training with children under the age of 21 years old. Other EPs in a pediatric group must meet the 30% threshold. Please note that pediatricians practicing predominantly in FQHC/RHCs must meet the 30% Medicaid patient volume threshold (including Medical Assistance and Needy patient encounters).	20% (30% FQHC/ RHC)
EPs Practicing Predominantly in an FQHC/RHC	***Numerator:*** Can also include needy individuals in the numerator totals. Needy individuals are those who receive services paid by Medicaid, CHIP or some other auditable reduced payment scale.	30%

Needy Patient Volume – Applies only to EPs Who Practice Predominantly in an FQHC/RHC

"Needy population encounter" means:

- The services were performed for individuals enrolled in Medicaid and Children's Health Insurance Program;
- The services were furnished at no cost; and,
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

"Practices predominantly" means that more than 50 percent of your patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of 6 months either in the most recent calendar year or the twelve months preceding the attestation date.

Group Volume Calculation

Incentive payments are for individual providers, however, individual providers practicing in clinics and group practices (including FQHCs and RHCs) are allowed to use the practice or clinic Medicaid patient volume (or needy population patient volume, insofar as it applies) for their patient volume. **Note**: The group NPI must define the 'group' and all members of the group must apply in an identical manner. EPs should enter the group NPIs in the group practice provider ID field. The following conditions apply to group practice calculations:

1. There must be an auditable data source to support the group's patient volume determination.

2. The group methodology is not appropriate for eligible professionals who see commercial, Medicare, or self-pay exclusively.

3. EPs have the capability to enter four (4) group NPIs. If there are more than four (4) group NPIs please indicate by checking the box in MAPIR described as *"additional group practice provider IDs."* You will be required to upload the documentation for all additional group NPI numbers and provider names in MAPIR.

4. If you are an eligible professional in a group that practices predominantly in an FQHC or RHC then you can include needy population encounters as part of your patient volume.

Provider Incentive Payments

The federal rules also set forth the EP EHR incentive payments. EPs may receive up to $63,750 in six incentive payments by participating in 6 program years over the life of the incentive program. It is not necessary for EPs to participate in 6 consecutive years, unless joining the program in 2016, to receive the full incentive payment of $63,750, (see **Figure 3** below). Eligible pediatricians that reach the 20 percent of their total patient volume but not 30 percent may receive up to $42,500 through six incentive payments over the life of the program. The pediatrician incentive payments table, (*see* **Figure 4** below), provides an overview of incentive payments over the life of the Connecticut Medical Assistance EHR Incentive Program.

Figure 3: Maximum Incentive Payments for Connecticut Medical Assistance

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Figure 4: Pediatrician Connecticut Medical Assistance EHR Incentive Payments

(Between 20 – 29 Percent)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$14,167					
CY 2012	$5,667	$14,167				
CY 2013	$5,667	$5,667	$14,167			
CY 2014	$5,667	$5,667	$5,667	$14,167		
CY 2015	$5,667	$5,667	$5,667	$5,667	$14,167	
CY 2016	$5,665	$5,667	$5,667	$5,667	$5,667	$14,167
CY 2017		$5,665	$5,667	$5,667	$5,667	$5,667
CY 2018			$5,665	$5,667	$5,667	$5,667
CY 2019				$5,665	$5,667	$5,667
CY 2020					$5,665	$5,667
CY 2021						$5,665
TOTAL	$42,500	$42,500	$42,500	$42,500	$42,500	$42,500

Adopt, Implement or Upgrade (AIU) and Meaningful Use

The goal of the Connecticut Medical Assistance EHR Incentive Program is to promote the adoption, implementation, upgrade, and meaningful use of certified EHRs. **For the first payment year of the program**, eligible professionals will be required to attest to and demonstrate to one of the following:

- **Adoption**: Acquired, purchased or secured access to certified EHR technology.
- **Implementation**: Installed or commenced utilization of certified EHR technology capable of meeting meaningful use requirements.
- **Upgrade:** Expanded the available functionality of certified EHR technology capable of meeting meaningful use requirements, including staffing, maintenance, and training, or upgrade from existing EHR technology to a federally-certified EHR system.

For subsequent payment years, eligible professionals will be required to attest to and demonstrate to

- **Meaningful Use** of the certified EHR technology. Providers will need to attest to a 90 day period of meaningful use from the current calendar year for their second payment year, but will need to attest to a full year of meaningful use for all subsequent payment years.

- For 2014 only, all EPs regardless of their stage of meaningful use are only required to demonstrate meaningful use of a 3-month EHR reporting period. CMS is permitting this one-time 3-month reporting period only so that providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.

The CMS Final Rule describes multiple stages for determining meaningful use (MU), each with its own separate measurements and criteria. The stages represent a graduated approach to arriving at the ultimate goal. Only Stage 1 was described in detail in the Final Rule. On September 4 2012, CMS published a final rule that specifies the Stage 2 criteria. The criteria for Stage 3 and beyond will be described in future rulemaking.

An Eligible Professional who works at multiple locations, but does not have certified EHR technology available at all of them:

- Will attest that 50% of their total patient encounters are at locations where certified EHR technology is available
- Will base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

Objectives: What every eligible professional is required to achieve in order to be able to show that they are meaningfully using their EHR.

Measures: The minimum requirement to achieve each objective. Every objective has an associated measure, which the eligible professional must meet or surpass.

Exclusions: There are exclusions that exempt providers from having to meet specific objectives. If the provider meets the qualifications for any exclusion, then they will not have to report on that objective and can still receive a full EHR incentive payment. These exclusions may be applicable to certain specialists who do not perform the actions specified in the objective as a normal scope of practice.

Stage 1 Criteria: Stage 1 requires providers to capture health information in a structured format, using the information to track key clinical conditions (for care coordination purposes), implementing clinical decision support tools to facilitate disease and medication management and using EHRs to engage patients and families and reporting clinical quality measures and public health information.

In addition to the two general requirements mentioned above, eligible professionals must complete:

- 13 Core Objectives prior (examples: CPOE, e-prescribing, record demographics, etc.)
- 5 Objectives out of 9 from menu set (examples: Drug-formulary checks, incorporate clinical lab tests as structured data, generate lists of patients by specific conditions, etc.)
- 9 of 64 Clinical Quality Measures covering at least 3 National Quality Strategy domains

Here is a link to the CMS Meaningful Use Stage 1 Table of Contents for Core and Menu Set Objectives for further reference:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MU_TableOfContents.pdf

Stage 2 Criteria: Stage 2 is being implemented in 2014. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2. For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 3-month EHR reporting period.

In addition to the two general requirements mentioned above, eligible professionals must complete:

- 17 Core Objectives (examples: CPOE, e-prescribing, record demographics, etc.)
- 3 Objectives out of 6 from menu set (examples: Electronic notes, imaging results, family health history etc.)
- 9 of 64 Clinical Quality Measures covering at least 3 National Quality Strategy domains

Here is a link to the CMS Meaningful Use Stage 2 Table of Contents for Core and Menu Set Objectives for further reference:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

Clinical Quality Measures - In addition to meeting the thresholds for the core and menu objectives, all eligible professionals have to report on **Clinical Quality Measures**.

Here is a link to the CMS Additional Information Regarding Clinical Quality Measures for 2014 EHR Incentive Programs:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf

Attestations and Audits

CMS requires states to ensure that payments are being made to the right person, at the right time, for the right reason. In order to receive an incentive payment, eligible professionals will be attesting to, among other things, whether they are using a certified EHR, demonstrating adopting, implementing or upgrading (AIU) certified EHR technology, demonstrating meaningful use, etc.

States will be required to "look behind" provider attestations which will require audits both pre- and post-pay. CMS believes a combination of pre-payment and post-payment reviews will result in accurate payments and timely identification of overpayments.

All information submitted in the MAPIR application is subject to review. Applicants have the option to submit additional information, (e.g., copies of receipts, contracts, and other documentation related to adopt, implement, and upgrade), as part of the application process by uploading the documentation directly into the MAPIR application or by email to: ctmedicaid-ehr@hp.com.

MAPIR Attestations

Professionals will need to verify the information displayed in MAPIR and will also need to enter additional required data elements and make attestations about the accuracy of data elements entered in MAPIR. For example, applicants will need to demonstrate that they meet Medicaid patient volume thresholds, that

they are adopting, implementing, or upgrading federally-certified EHR systems, and that they meet all other federal program requirements.

The MAPIR system design is based on the CMS Final Rule for the EHR Incentive Program and Connecticut's specific eligibility criteria. A series of reviews will identify applicants who do not appear to be eligible, for example:

- Hospital-based providers
- Applicants who do not meet patient volume thresholds
- Ineligible provider type
- Current sanctions

These MAPIR system reviews will help to identify potential overpayments before they occur.

Audits

The Department may access all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to verify provider attestations or conduct pre-payment or post-payment audits to assure compliance with the provisions of sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies and other regulatory and statutory requirements. The Department may disallow or recover any amounts paid or pending to the provider for which required documentation is not maintained or not provided to the department upon request.

For purposes of documenting AIU, the provider shall make available to the department all relevant documents, including, but not limited to, one or more of the following documents, as directed by the department:

(1) Contract;
(2) software license;
(3) receipt or evidence of cost;
(4) purchase order;
(5) evidence of cost or contract for training; or
(6) payroll record demonstrating hiring of staff to assist with the implementation.

After conducting an audit, if the Department finds that the provider was not eligible for payments made to the provider, the Department may disallow and recover those funds. The provider shall promptly repay all disallowed funds to the department not more than forty-five days after receiving notice of the disallowance. In addition to taking any other lawful actions, the department may also offset such funds against current or future payments that the department otherwise would have made to the provider.

A provider aggrieved by a decision in a final written audit conducted under this section may request a written review from the Department. The provider shall request such review in writing and not later than thirty days after the Department's final audit report was issued, together with a detailed written description of each specific item of aggrievement. The scope of the review shall not include or consider facts or circumstances outside of the audit and the final written audit report. An individual other than a person who conducted the audit or made the department's final audit determination shall conduct the review. At the discretion of the person presiding over the review, the person may make informal inquiries to the provider or the Department; accept written statements from the provider and the

department; and hold an informal conference with the department and the provider for the purpose of fact finding, accepting oral statements, or hearing witness testimony, after giving appropriate notice thereof to the provider and the department. After completing the final review, the person presiding over the review shall issue a final written decision regarding what, if any action will be taken, including, but not limited to, revising the final written audit or any other action within the scope of the department's authority.

Overpayments

MAPIR will be used to store and track records of incentive payments for all participating EPs. The Department will regularly monitor payments to ensure overpayments are not made. Once an overpayment is identified MAPIR will be used to determine the amount of payments that have been made and that must be returned by EPs.

When overpayments are identified, the Department will initiate the payment recoupment process and communicate with CMS on repayments. The Department will recover any overpayments from instances of abuse; however, overpayments identified as a result of a fraud conviction are handled in conjunction with the Medicaid Fraud Control Unit.

The Department will request that providers submit overpayments by check. If a provider fails to submit a payment by check within 90 calendar days of the notice to return the overpayment, the Department will take other measures to recoup the overpayment. Federal law requires the Department to return overpayments within one (1) year of identification.

Appeals

A provider aggrieved by a decision concerning only the issues set forth in 42 CFR 495.370(a) or section 17b-34(c) of the Connecticut General Statutes may request an initial review of the Department's determination, and such review shall occur only if the Department receives the provider's written request for an initial review, together with any supporting documents or data, not more than thirty days after the provider received the department's determination.

An individual other than the person who made the Department's determination shall conduct the initial review. The individual who conducts the initial review shall issue a written decision to the provider not more than thirty days after the Department receives the request for initial review.

If the provider is aggrieved by the outcome of the initial review, the provider may request an administrative hearing in writing to the commissioner, together with a detailed written description of all items of aggrievement, not more than fourteen days after the date the written initial review decision was issued.

The Department shall conduct an administrative hearing requested pursuant to subsection (c) of this section in accordance with chapter 54 of the Connecticut General Statutes.

Medical Assistance Provider Incentive Repository (MAPIR) System

The Medical Assistance Provider Incentive Repository (MAPIR) is a Web-based program administered by Connecticut Medicaid program that allows Eligible Professionals and Eligible Hospitals to apply for incentive payments to help defray the costs of a certified EHR system.

Per the final federal rule, Eligible Professionals under the Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a Federally Qualified Health Center or Rural Health Center that is led by a physician assistant

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an Eligible Professional must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume, and is a pediatrician
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

Note: Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.

To apply for the Medicaid EHR Incentive Payment Program, Eligible Professionals must first register at the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (R&A). Once registered, they can submit an application and attest online using MAPIR.

This manual provides step-by-step directions for using MAPIR and submitting your application to the Connecticut Medicaid EHR Incentive Payment Program.

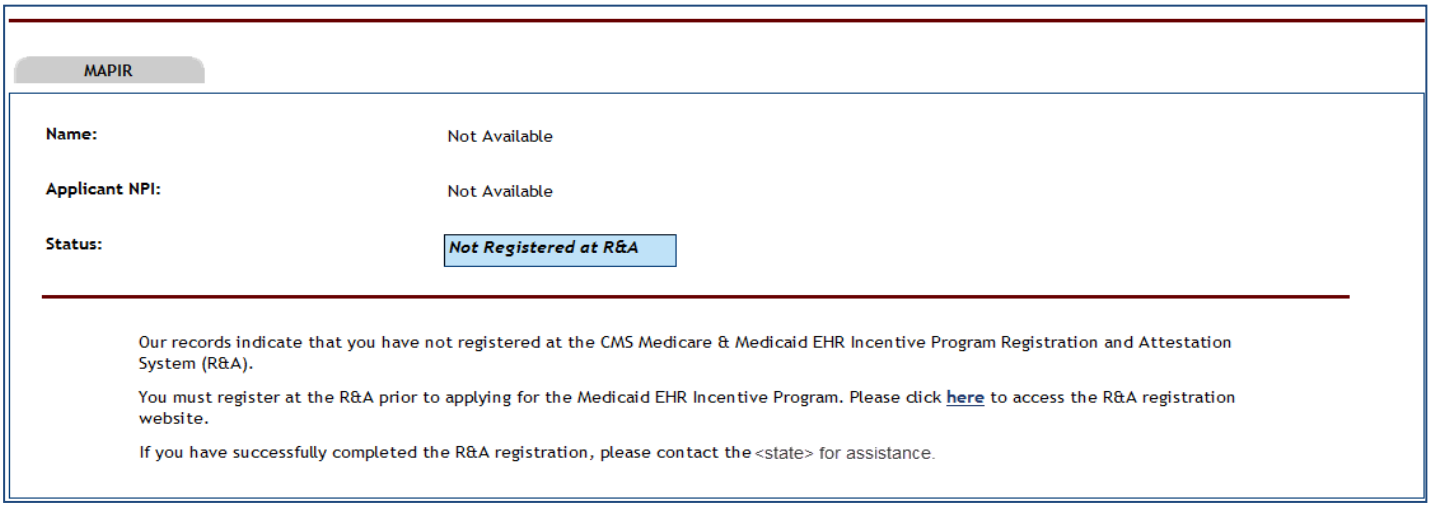
Before You Begin in MAPIR

There are several pre-requisites to applying for state Medicaid EHR Incentive payments using MAPIR.

1. Complete your CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) registration.
2. Identify one individual from your organization who will be responsible for completing the MAPIR application and attestation information. This person can also serve as a contact point for state Medicaid communications.
3. Gather the necessary information to facilitate the completion of the application and attestation process.

Complete your R&A registration.

You must register at the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (also known as R&A) before accessing MAPIR. If you access MAPIR and have not completed this registration, you will receive the following screen.


MAPIR
Name:
Not Available
Applicant NPI:
Not Available
Status:
Not Registered at R&A
Our records indicate that you have not registered at the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A).
You must register at the R&A prior to applying for the Medicaid EHR Incentive Program. Please click here to access the R&A registration website.
If you have successfully completed the R&A registration, please contact the <state> for assistance.

Please access the federal Web site below for instructions on how to do this or to register:

For general information regarding the Incentive Payment Program:
http://www.cms.gov/EHRIncentivePrograms

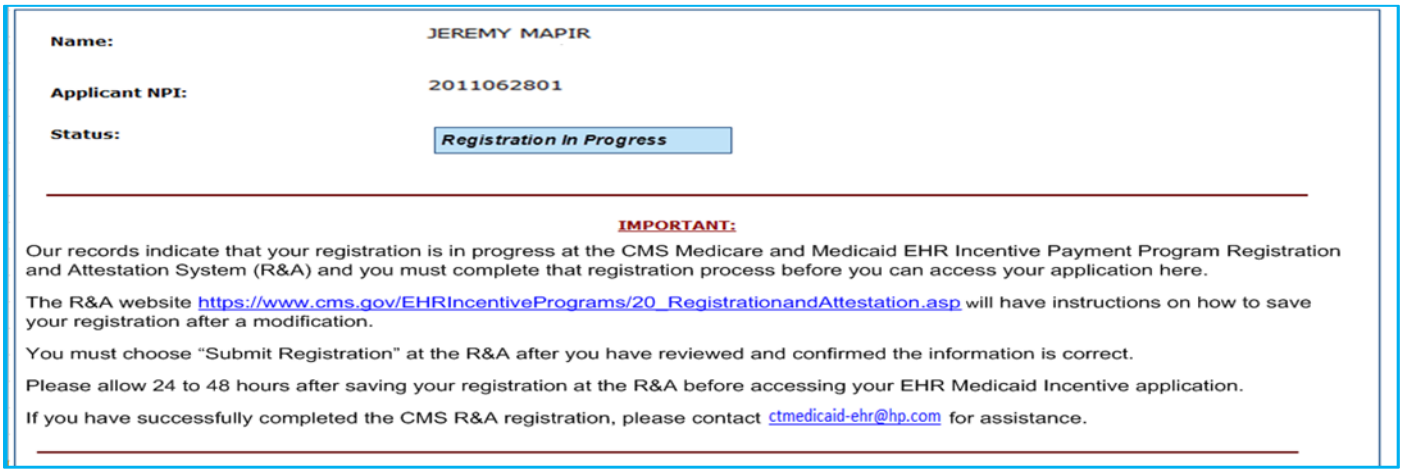
To register:
https://ehrincentives.cms.gov/hitech/login.action

You will not be able to start your MAPIR application process unless you have successfully completed this federal registration process. When MAPIR has received and matched your provider information, you will receive an email to begin the MAPIR application process. Please allow at least two days from the time you complete your federal registration before accessing MAPIR due to the necessary exchange of data between these two systems.

Changes to your R&A Registration

Please be aware that when accessing your R&A registration information, should any changes be initiated but not completed, the R&A may report "Registration in Progress". This will result in your application being placed in a hold status within MAPIR until the R&A indicates that any pending changes have been finalized. You must complete your registration changes on the R&A website prior to accessing MAPIR or certain capabilities will be unavailable. For example, it will not be possible to submit your application,

create a new application, or abort an incomplete application. If you access MAPIR to perform the above activities and have not completed your registration changes, you will receive the following screen.



Name: JEREMY MAPIR

Applicant NPI: 2011062801

Status: *Registration in Progress*

IMPORTANT:

Our records indicate that your registration is in progress at the CMS Medicare and Medicaid EHR Incentive Payment Program Registration and Attestation System (R&A) and you must complete that registration process before you can access your application here.

The R&A website https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp will have instructions on how to save your registration after a modification.

You must choose "Submit Registration" at the R&A after you have reviewed and confirmed the information is correct.

Please allow 24 to 48 hours after saving your registration at the R&A before accessing your EHR Medicaid Incentive application.

If you have successfully completed the CMS R&A registration, please contact ctmedicaid-ehr@hp.com for assistance.

Should the R&A report your registration "Registration in Progress" and an application be incomplete or under review (following the application submission), MAPIR will send an email message reporting that such notification has been received if a valid email address was provided by either the R&A, or by the provider on the incentive application in MAPIR. Please allow at least two days from the time you complete your federal registration changes before accessing MAPIR due to the necessary exchange of data between these two systems.

Identify one individual to complete the MAPIR application.

MAPIR is accessed via the secure provider portal through the Connecticut Medical Assistance Program's secure provider Web portal at www.ctdssmap.com. You need an ID and PIN to log onto the secure site. If you do not have a logon ID and/or PIN, please contact HP Enterprise Services at 1-855-313-6638. The individual who sets up the secure account is the main account administrator and can set up subordinate ID(s) to allow for third party attestation. Once an individual has started the MAPIR application process with their Internet/portal account, they cannot switch to another account during that program year. MAPIR will allow the user to save the information entered and return later to complete an application; however, only the same individual's Internet/portal account will be permitted access to the application once it has been started.

Gather the necessary information to facilitate the completion of the required data.

MAPIR will request specific information when you begin the application process. To facilitate the completion of the application, it is recommended that you review the Connecticut Medical Assistance Program's EHR Incentive Payment Program Web site at www.ctdssmap.com to understand what information will be required. From the home page click on EHR Incentive Program under the Provider link; once on the EHR Incentive Program Web page, click on "Professional Instructions" under EHR Incentive Program Provider Registration. At a minimum, you should have the following information available:

- Information submitted to the R&A; make sure you match the MAPIR application with the Registration ID you received for your application with the R&A
- Medicaid Patient Volume and associated timeframes
- The CMS EHR Certification ID that you obtained from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) Web site (http://onc-chpl.force.com/ehrcert)
- Meaningful Use measures data if attesting to Meaningful Use

Using MAPIR

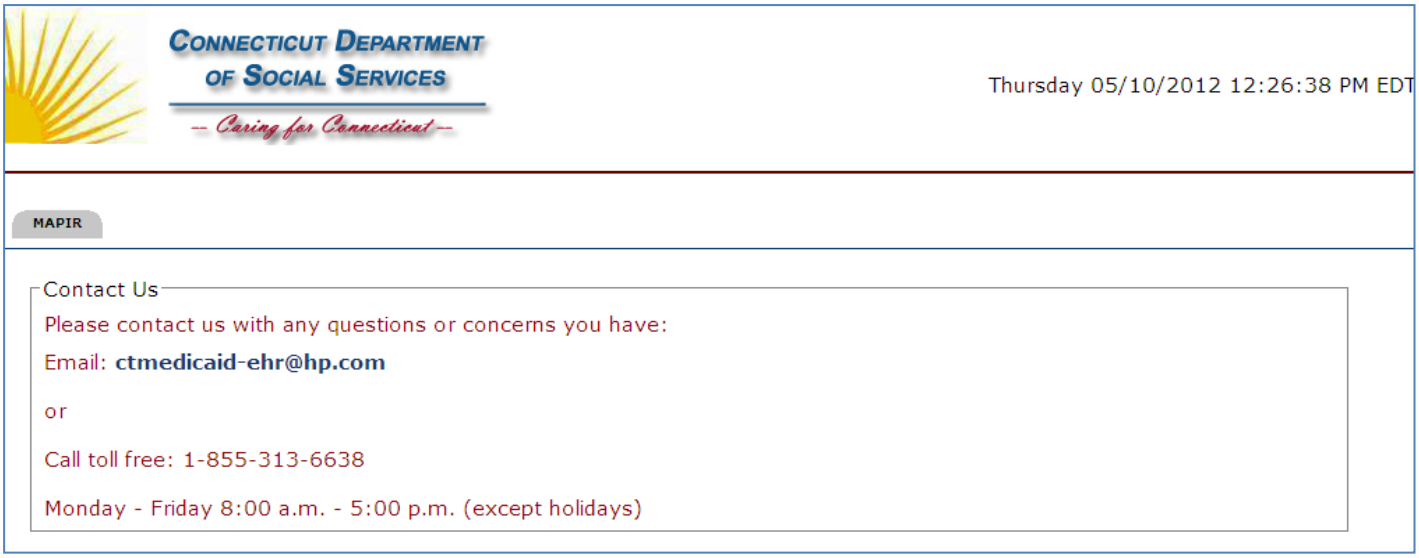
MAPIR uses a tab arrangement to guide you through the application. You must complete the tabs in the order presented. You can return to previous tabs to review the information or make modifications until you submit the application. You cannot proceed without completing the next tab in the application progression, with the exception of the Get Started and Review tabs which you can access anytime.

Once you submit your application, you can no longer modify the data. It will only be viewable through the Review tab. Also, the tab arrangement will change after submission to allow you to view status information.

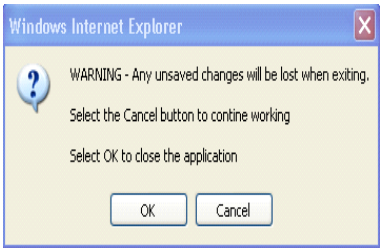
As you proceed through the application process, you will see your identifying information such as Name, National Provider Identifier (NPI), Tax Identification Number (TIN), Payment Year, and Program year at the top of most screens. This is information provided by the R&A.

A **Print** link is displayed in the upper right-hand corner of most screens to allow you to print information entered. You can also use your Internet browser print function to print screen shots at any time within the application.

There is a **Contact Us** link with contact instructions should you have questions regarding MAPIR or the Medicaid Incentive Payment Program.


CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --
Thursday 05/10/2012 12:26:38 PM EDT
MAPIR
Contact Us
Please contact us with any questions or concerns you have:
Email: ctmedicaid-ehr@hp.com
or
Call toll free: 1-855-313-6638
Monday - Friday 8:00 a.m. - 5:00 p.m. (except holidays)

Most MAPIR screens display an **Exit** link that closes the MAPIR application window. If you modify any data in MAPIR without saving, you will be asked to confirm if the application should be closed (as shown to the right).

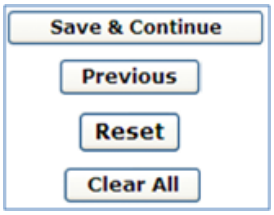

Windows Internet Explorer
WARNING - Any unsaved changes will be lost when exiting.
Select the Cancel button to contine working
Select OK to close the application
OK
Cancel

You should use the **Save & Continue** button on the screen before exiting or data entered on that screen will be lost.

The **Previous** button always displays the previous MAPIR application window without saving any changes to the application.

The **Reset** button will restore all unsaved data entry fields to their original values.

The **Clear All** button will remove standard activity selections for the screen in which you are working.

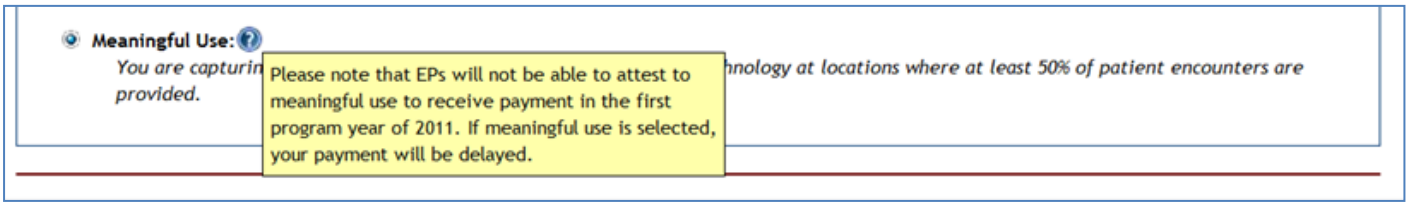


A (*) red asterisk indicates a required field. Help icons, located next to certain fields, display help content specific to the associated field when you hover the mouse over the icon.

Note: Use the MAPIR Navigation buttons in MAPIR to move to the next and previous screens. Do not use the browser buttons as this could result in unexpected results.

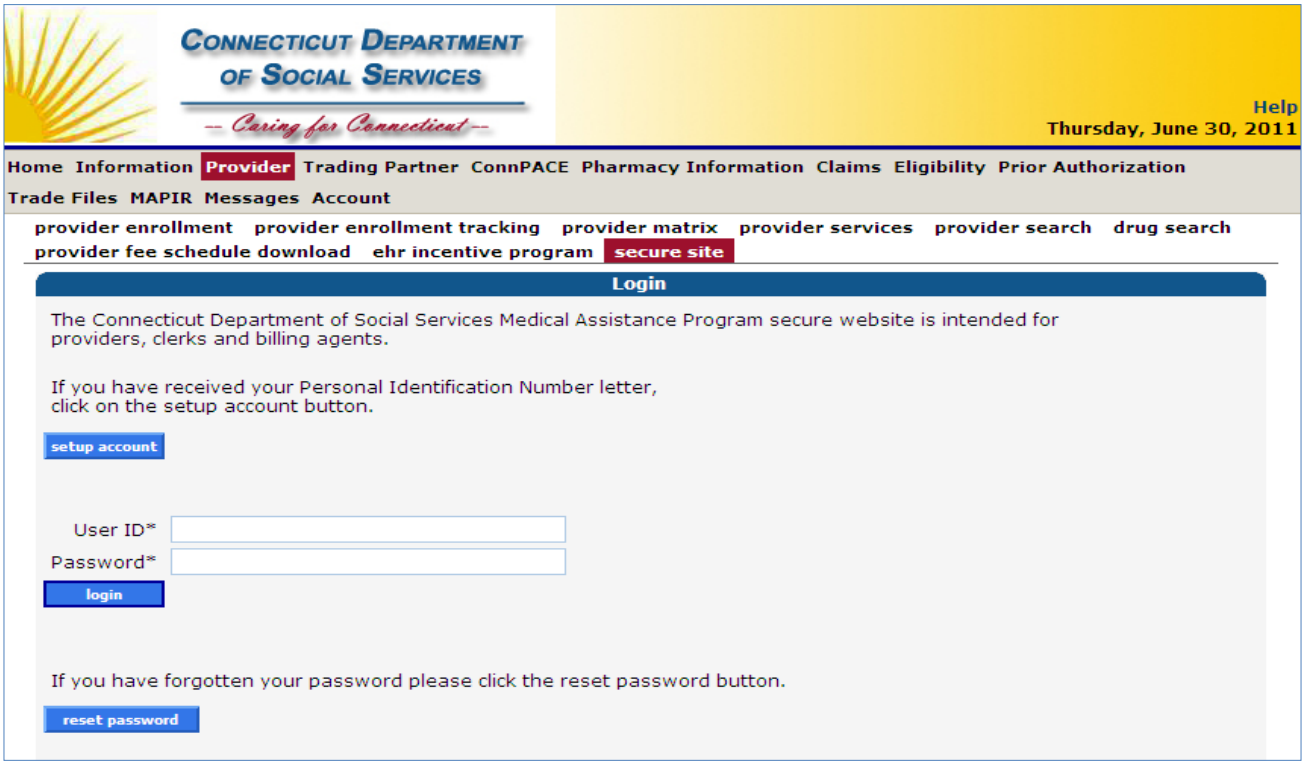
As you complete your incentive application you may receive validation messages requiring you to correct the data you entered. These messages will appear above the navigation button. See the Additional User Information section for more information.

Many MAPIR screens contain help icons to give the provider additional details about the information being requested. Moving your cursor over the will reveal additional text providing more details.

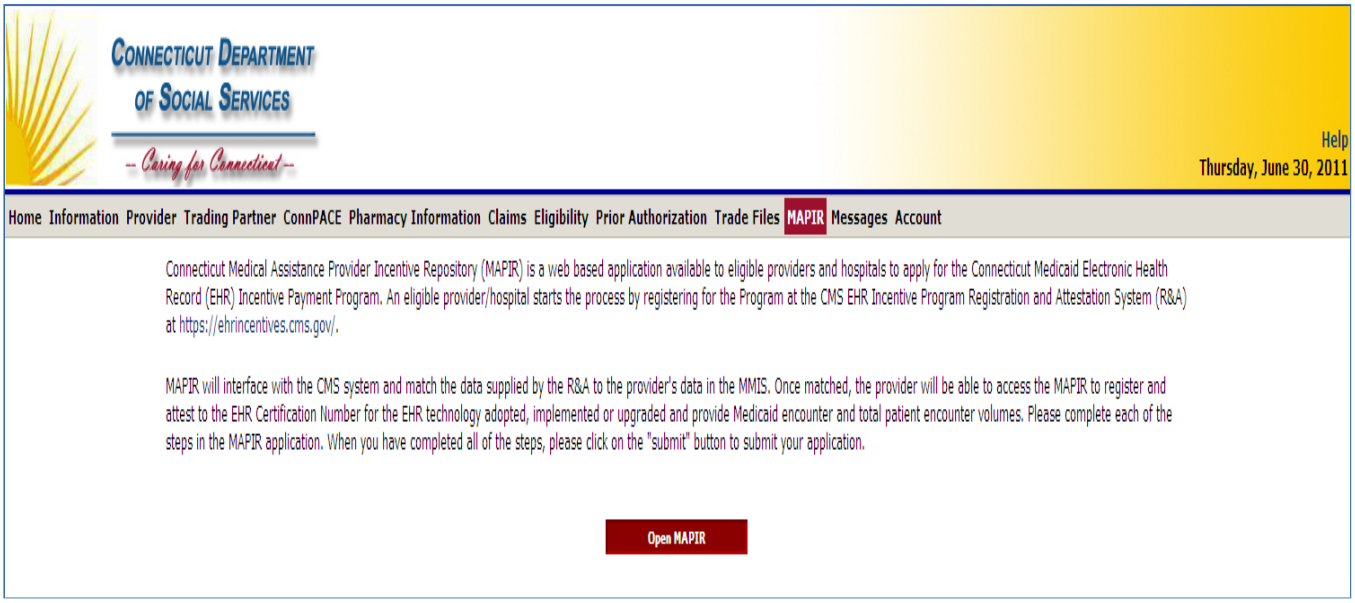

Meaningful Use:
You are capturin
nology at locations where at least 50% of patient encounters are
provided.
Please note that EPs will not be able to attest to meaningful use to receive payment in the first program year of 2011. If meaningful use is selected, your payment will be delayed.

Step 1 – Getting Started

Log in to the Connecticut Medical Assistance Program's secure provider Web portal account at www.ctdssmap.com. NOTE: The secure provider portal is located under Provider, Secure Site.


Connecticut Department of Social Services
Caring for Connecticut
Help
Thursday, June 30, 2011
Home Information Provider Trading Partner ConnPACE Pharmacy Information Claims Eligibility Prior Authorization
Trade Files MAPIR Messages Account
provider enrollment provider enrollment tracking provider matrix provider services provider search drug search
provider fee schedule download ehr incentive program secure site
Login
The Connecticut Department of Social Services Medical Assistance Program secure website is intended for providers, clerks and billing agents.
If you have received your Personal Identification Number letter, click on the setup account button.
setup account
User ID*
Password*
login
If you have forgotten your password please click the reset password button.
reset password

Find the MAPIR link on the gray menu bar and click the Open MAPIR button to access the **MAPIR** screen.


Connecticut Department of Social Services
Caring for Connecticut
Help
Thursday, June 30, 2011
Home Information Provider Trading Partner ConnPACE Pharmacy Information Claims Eligibility Prior Authorization Trade Files MAPIR Messages Account
Connecticut Medical Assistance Provider Incentive Repository (MAPIR) is a web based application available to eligible providers and hospitals to apply for the Connecticut Medicaid Electronic Health Record (EHR) Incentive Payment Program. An eligible provider/hospital starts the process by registering for the Program at the CMS EHR Incentive Program Registration and Attestation System (R&A) at https://ehrincentives.cms.gov/.
MAPIR will interface with the CMS system and match the data supplied by the R&A to the provider's data in the MMIS. Once matched, the provider will be able to access the MAPIR to register and attest to the EHR Certification Number for the EHR technology adopted, implemented or upgraded and provide Medicaid encounter and total patient encounter volumes. Please complete each of the steps in the MAPIR application. When you have completed all of the steps, please click on the "submit" button to submit your application.
Open MAPIR

The screen on the following page is the Medicaid EHR Incentive Program Participation Dashboard. This is the first screen you will access to begin the MAPIR application process.

This screen displays your incentive applications. The incentive applications that you are eligible to apply for are enabled. Your incentive applications that are in a Completed status are also enabled; however, you may only view these applications.

The **Stage** is automatically associated with a stage of Meaningful Use that is required by the current CMS rules, or by the rules that were in effect at the time when the application was submitted. This column displays the Stage and Attestation Phase attained by the current and previous applications. The Stage column will be blank for incentive applications in a Not Started status.

If you are in Program Year 2014 and have already attested to two years of Stage 1 Meaningful Use, you may have the option of attesting to a third year of Stage 1 Meaningful Use.

You must attest to two years of Stage 1 Meaningful Use before proceeding to Stage 2 Meaningful Use, and three years of Stage 1 if you have attested to Meaningful Use in Program Year 2011. You must then proceed to attest to two years of Stage 2 Meaningful Use.

If it is your first year participating (Payment Year 1), the Stage column will be blank. Once you have submitted the incentive application, the Stage column will display Adoption, Implementation, Upgrade, or Meaningful Use.

If it not your first year participating (Payment Year greater than 1), the Stage column will only display the Stage, not the Attestation Phase, until you submit the incentive application.

The **Status** will vary, depending on your progress with the incentive application. The first time you access the system the status should be **Not Started**. From this screen you can choose to edit and view incentive applications in an Incomplete or Not Started status. You can only view incentive applications that are in a Completed, Denied, or Expired status.

Also from this screen, you can choose to abort an incentive application that is in an Incomplete status. When you click **Abort** on an incentive application, all progress will be eliminated for the incentive application.

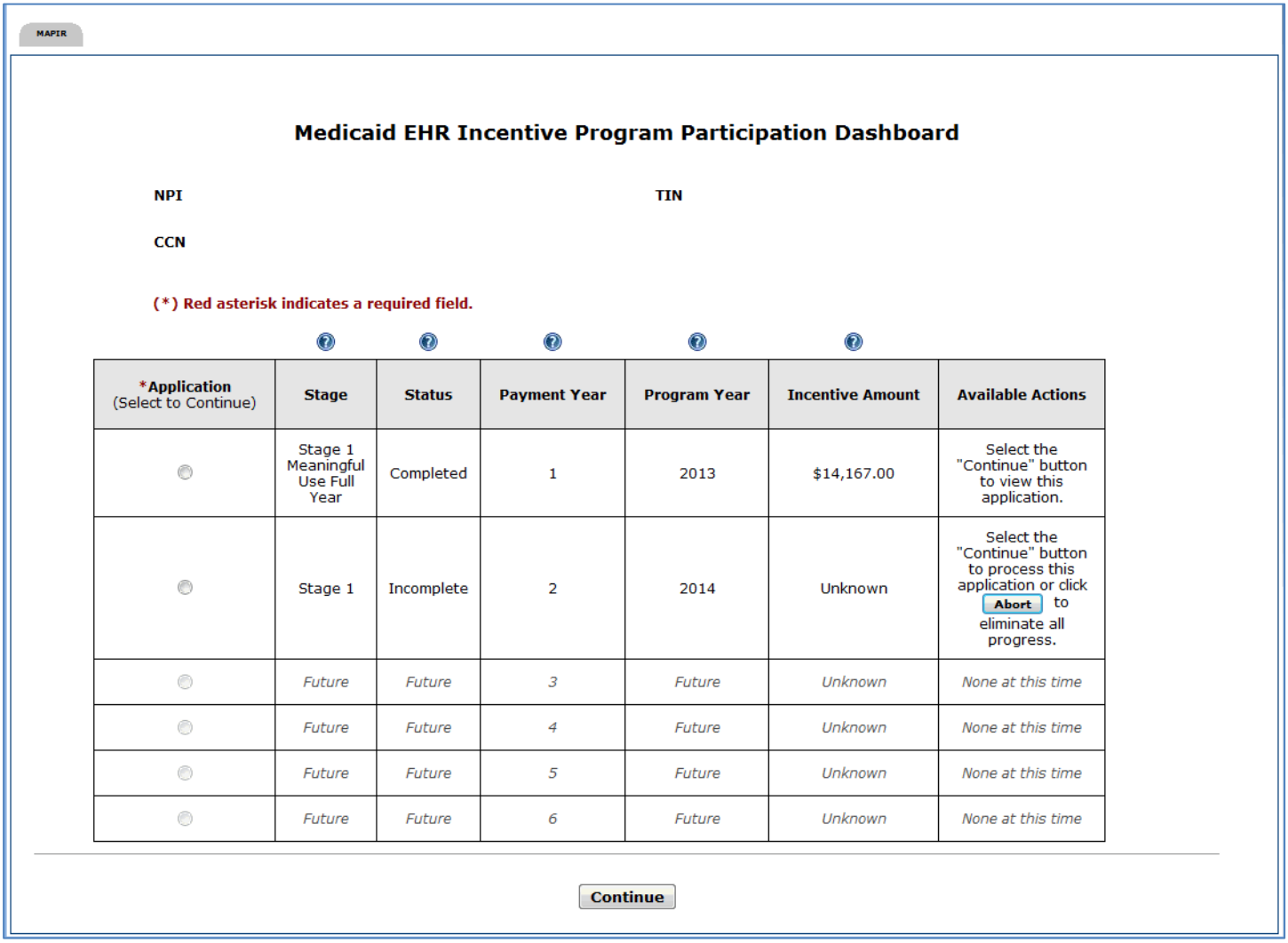
When an incentive application has completed the payment process, the status will change to **Completed**.

The screen on the following page displays an EP that is in the second year of Stage 1. The Attestation Phase is not displayed because the incentive application has not been submitted.

Select an application and click **Continue**.

If you are in Program Year 2014 and have selected an **Incomplete** State-to-State Switch or Program Switch incentive application on the Medicaid EHR Incentive Program Participation Dashboard, you may need to enter a delay reason. Proceed to page 207 of this guide.

If you have a State-to-State Switch or Program Switch incentive application that does not require a delay reason (delay reasons only apply for Program Year 2014 incentive applications), proceed to page 26.



Note: The state of Connecticut allows a grace period of 90 days after the calendar year end to allow eligible professionals to submit their attestation for a specific Program Year.* If two applications are showing for the same Payment Year, but different Program Years, one of your incentive applications is in the grace period. In this situation, the following message will display at the bottom of the screen.

> *You are in the grace period for program year <Year> which began on <Date> and ends on <Date>. The grace period extends the amount of time to submit an application for the previous program year. You have the option to choose the previous program year or the current program year.*

* To accommodate the Flexibility Rule for 2014, the grace period for 2014 Program Year runs through May 30, 2015.

You may only submit an application for one Program Year so once you select the application, the row for the application for the other Program Year will no longer display. If the incentive application is not completed by the end of the grace period, the status of the application will change to **Expired** and you will no longer have the option to submit the incentive application for that Program Year.

The R&A Not Registered or In Progress screen displays a status of *Not Registered at R&A* to indicate that you have not registered at the R&A, or the information provided during the R&A registration process does not match that on file with the state Medicaid Program. A Status of *Registration In Progress* indicates that

you have initiated but not completed R&A registration changes. If you feel this status is not correct you can click the Contact Us link in the upper right for information on contacting the state Medicaid program office. A status of *Not Started* indicates that the R&A and state MMIS information have been matched and you can begin the application process.

The **Status** will vary, depending on your progress with the application. The first time you access the system the status should be **Not Started**.

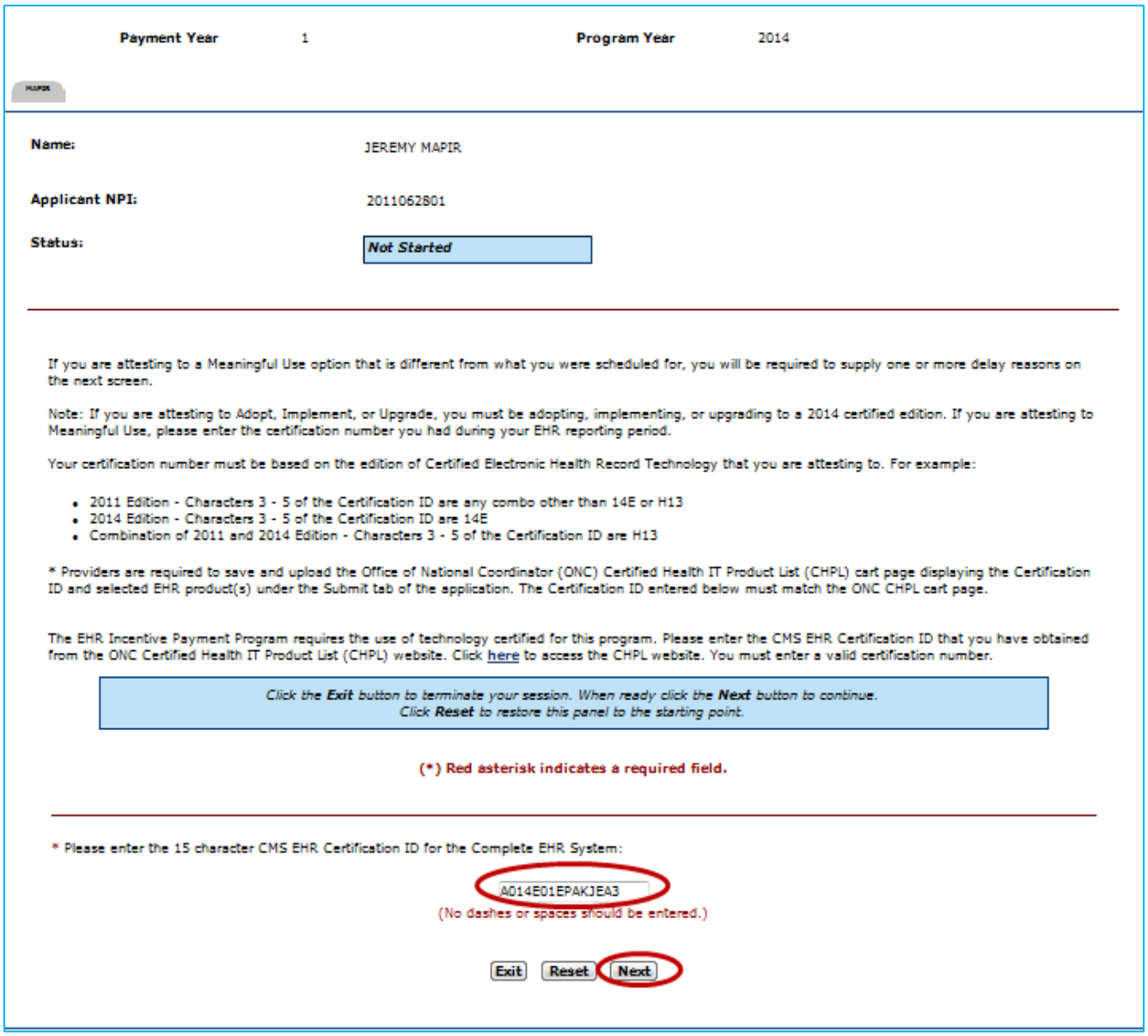
For more information on statuses, refer to the Additional User Information section later in this guide.

Enter the 15-character **CMS EHR Certification ID**.

Click **Next** to review your selection. Click **Reset** to restore this panel back to the starting point. Click **Exit** to exit MAPIR.

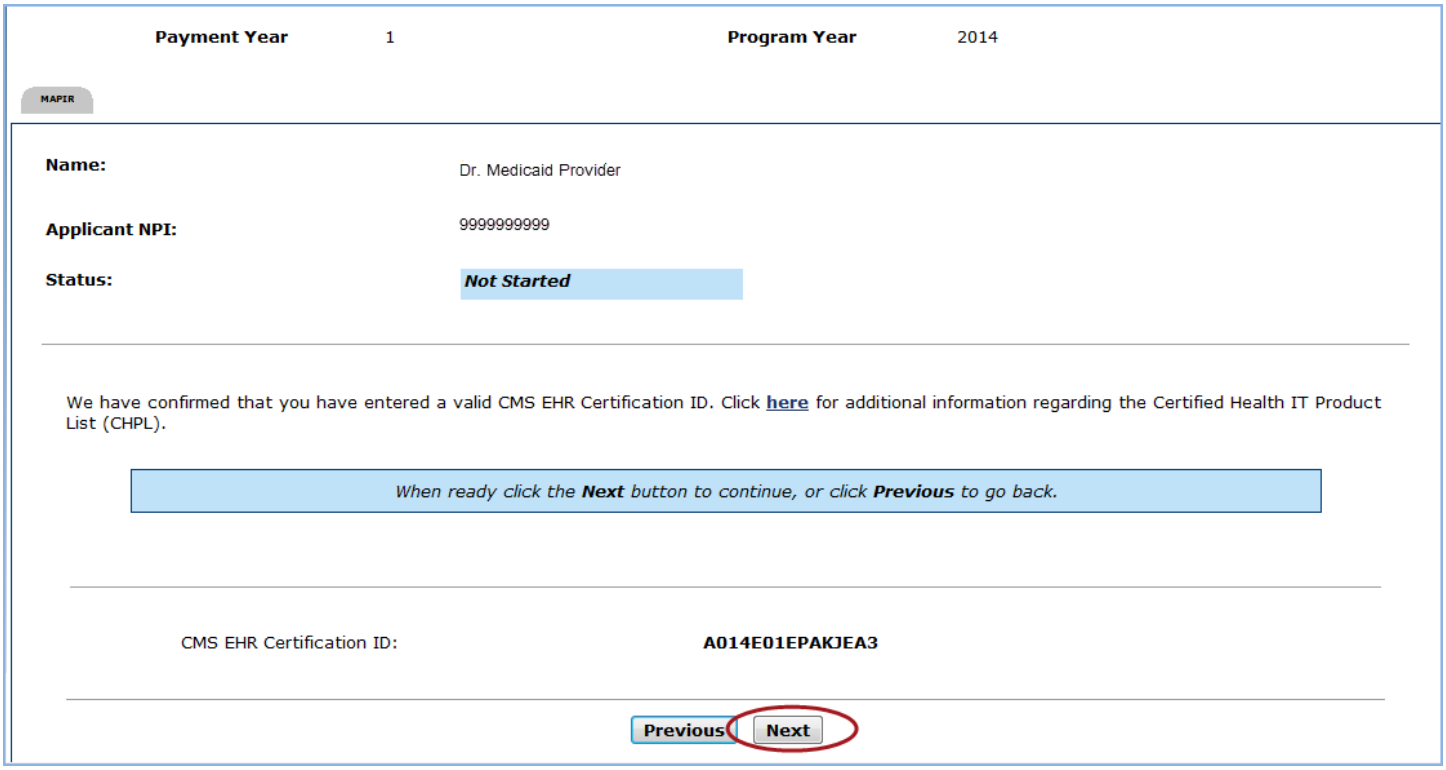
The system will perform an online validation of the CMS EHR Certification ID you entered.

A CMS EHR Certification ID can be obtained from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) website (http://onc-chpl.force.com/ehrcert)


Payment Year 1
Program Year 2014
Name: JEREMY MAPIR
Applicant NPI: 2011062801
Status: Not Started
If you are attesting to a Meaningful Use option that is different from what you were scheduled for, you will be required to supply one or more delay reasons on the next screen.
Note: If you are attesting to Adopt, Implement, or Upgrade, you must be adopting, implementing, or upgrading to a 2014 certified edition. If you are attesting to Meaningful Use, please enter the certification number you had during your EHR reporting period.
Your certification number must be based on the edition of Certified Electronic Health Record Technology that you are attesting to. For example:
2011 Edition - Characters 3 - 5 of the Certification ID are any combo other than 14E or H13
2014 Edition - Characters 3 - 5 of the Certification ID are 14E
Combination of 2011 and 2014 Edition - Characters 3 - 5 of the Certification ID are H13
* Providers are required to save and upload the Office of National Coordinator (ONC) Certified Health IT Product List (CHPL) cart page displaying the Certification ID and selected EHR product(s) under the Submit tab of the application. The Certification ID entered below must match the ONC CHPL cart page.
The EHR Incentive Payment Program requires the use of technology certified for this program. Please enter the CMS EHR Certification ID that you have obtained from the ONC Certified Health IT Product List (CHPL) website. Click here to access the CHPL website. You must enter a valid certification number.
Click the Exit button to terminate your session. When ready click the Next button to continue.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Please enter the 15 character CMS EHR Certification ID for the Complete EHR System:
A014E01EPAKJEA3
(No dashes or spaces should be entered.)
Exit
Reset
Next

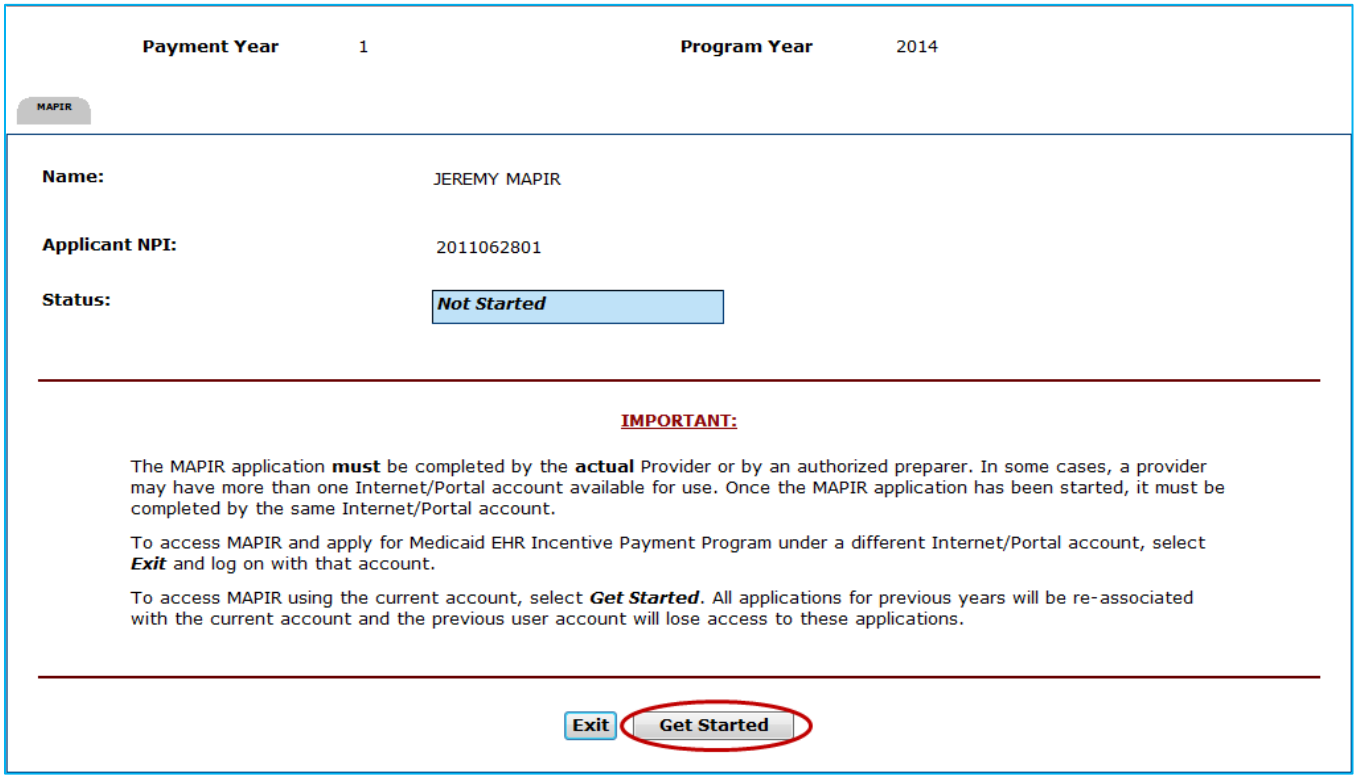
This screen confirms you successfully entered your **CMS EHR Certification ID**.
Click **Next** to continue, or click **Previous** to go back.

If you are in Program Year 2014, turn to page 205 of this guide.


Payment Year 1
Program Year 2014
MAPIR
Name:
Dr. Medicaid Provider
Applicant NPI:
9999999999
Status:
Not Started
We have confirmed that you have entered a valid CMS EHR Certification ID. Click here for additional information regarding the Certified Health IT Product List (CHPL).
When ready click the Next button to continue, or click Previous to go back.
CMS EHR Certification ID:
A014E01EPAKJEA3
Previous
Next

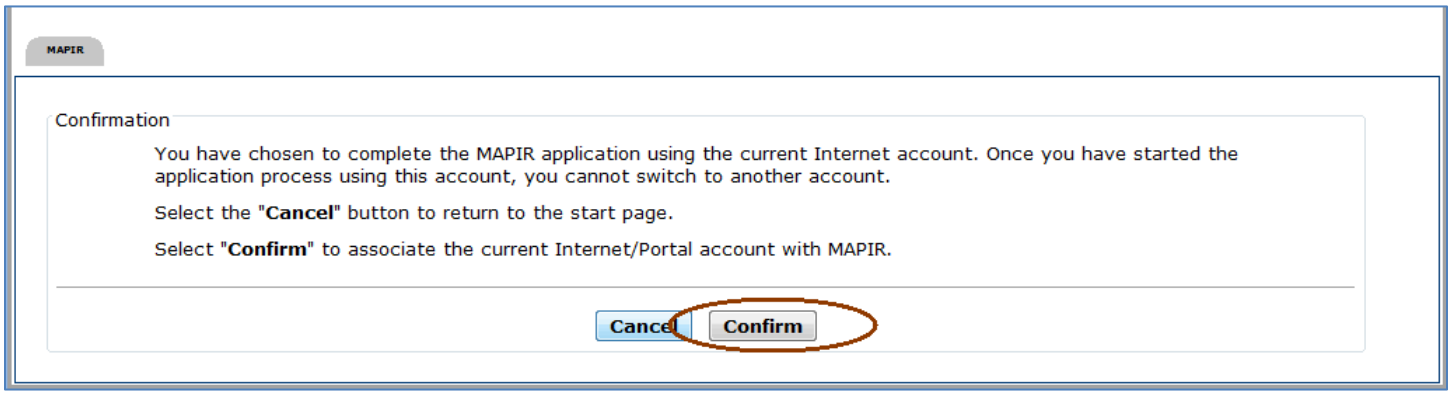
Click **Get Started** to access the **Get Started** screen or **Exit** to close the program.

If you click **Exit** or close the browser prior to clicking the **Get Started** button, you will lose the data you entered on the previous screens.


Payment Year 1
Program Year 2014
MAPIR
Name:
JEREMY MAPIR
Applicant NPI:
2011062801
Status:
Not Started
IMPORTANT:
The MAPIR application must be completed by the actual Provider or by an authorized preparer. In some cases, a provider may have more than one Internet/Portal account available for use. Once the MAPIR application has been started, it must be completed by the same Internet/Portal account.
To access MAPIR and apply for Medicaid EHR Incentive Payment Program under a different Internet/Portal account, select Exit and log on with that account.
To access MAPIR using the current account, select Get Started. All applications for previous years will be re-associated with the current account and the previous user account will lose access to these applications.
Exit
Get Started

If you selected an incentive application that you are not associated with, you will receive a message indicating a different Internet/Portal account has already started the Medicaid EHR Incentive Payment Program application process and that the same Internet/Portal account must be used to access the application for this Provider ID. If you are the new user for the provider and want to access the previous applications, you will need to contact the EHR Assistance Center either by email at ctmedicaid-ehr@hp.com or by phone at 1-855-313-6638.

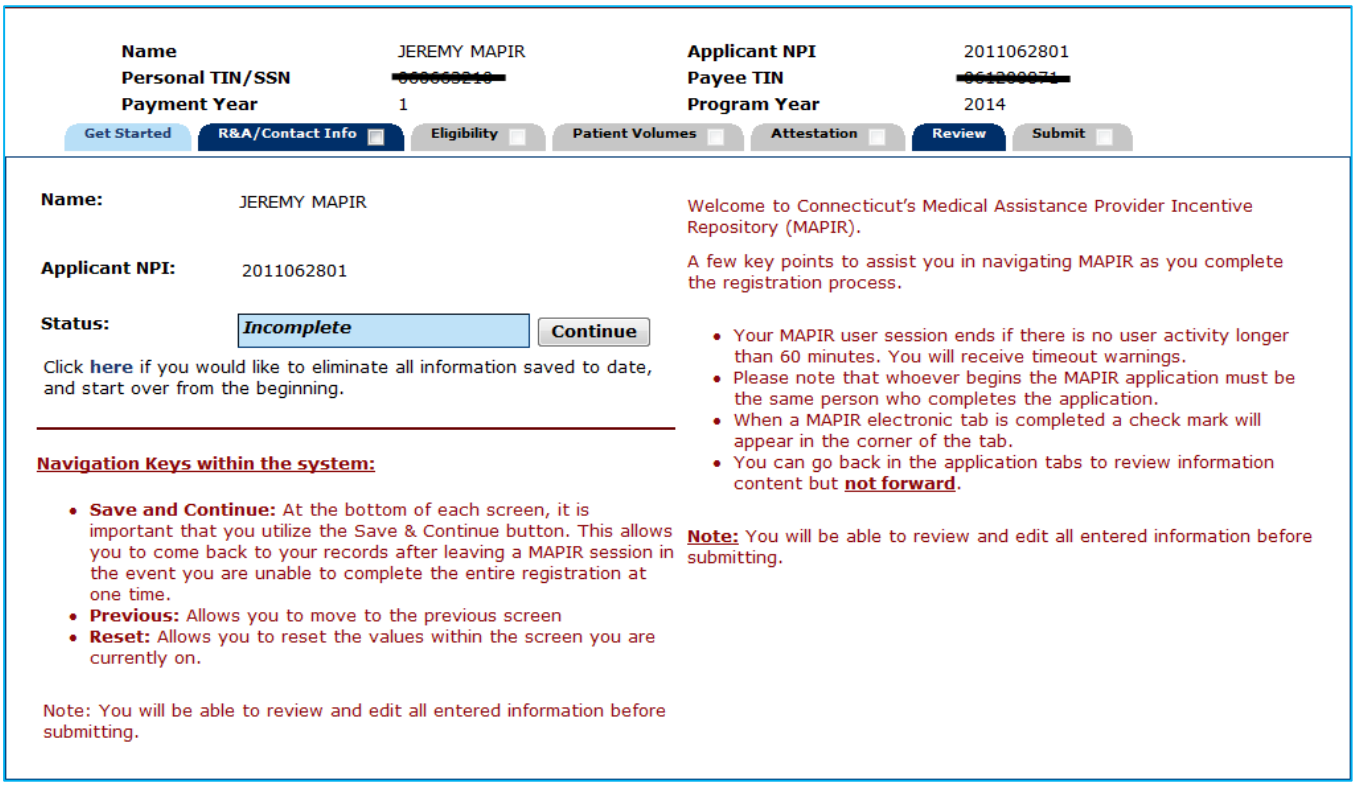
Click **Confirm** to associate the current Internet/Portal account with this incentive application.


MAPIR
Confirmation
You have chosen to complete the MAPIR application using the current Internet account. Once you have started the application process using this account, you cannot switch to another account.
Select the "Cancel" button to return to the start page.
Select "Confirm" to associate the current Internet/Portal account with MAPIR.
Cancel
Confirm

If you have a State-to-State Switch or Program Switch incentive application, you will not be able to proceed beyond this point. MAPIR is unable to assign a Stage to your incentive application. Contact ctmedicaid-EHR@hp.com for assistance.

The **Get Started** screen contains information that includes your **Name** and **Applicant NPI**. Also included is the current status of your incentive application.

Click **Continue** to proceed to the **R&A/Contact Info** section.


Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN
Payee TIN
Payment Year 1
Program Year 2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Name: JEREMY MAPIR
Applicant NPI: 2011062801
Status: Incomplete
Continue
Click here if you would like to eliminate all information saved to date, and start over from the beginning.
Navigation Keys within the system:
Save and Continue: At the bottom of each screen, it is important that you utilize the Save & Continue button. This allows you to come back to your records after leaving a MAPIR session in the event you are unable to complete the entire registration at one time.
Previous: Allows you to move to the previous screen
Reset: Allows you to reset the values within the screen you are currently on.
Note: You will be able to review and edit all entered information before submitting.
Welcome to Connecticut's Medical Assistance Provider Incentive Repository (MAPIR).
A few key points to assist you in navigating MAPIR as you complete the registration process.
Your MAPIR user session ends if there is no user activity longer than 60 minutes. You will receive timeout warnings.
Please note that whoever begins the MAPIR application must be the same person who completes the application.
When a MAPIR electronic tab is completed a check mark will appear in the corner of the tab.
You can go back in the application tabs to review information content but not forward.
Note: You will be able to review and edit all entered information before submitting.

Step 2 – Confirm R&A and Contact Info

When you completed the R&A registration, your registration information was sent to the state Medicaid program. This section will ask you to confirm the information sent by the R&A and matched with the Connecticut Medicaid program information. It is important to review this information carefully. The R&A information can only be changed at the R&A but Contact Information can be changed at any time prior to application submission.

The initial **R&A/Contact Info** screen contains information about this section.

Click **Begin** to access the **R&A/Contact Info** screen to confirm information and to enter your contact information.

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
The information you provided to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) will be displayed in this section.
You will need to verify the accuracy of information provided by the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A). If there are errors or discrepancies in the information, you need to return to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) to make these updates prior to moving forward in the MAPIR application process.
The following link will take you to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) to correct any errors noted: https://ehrincentives.cms.gov/hitech/login.action
Begin

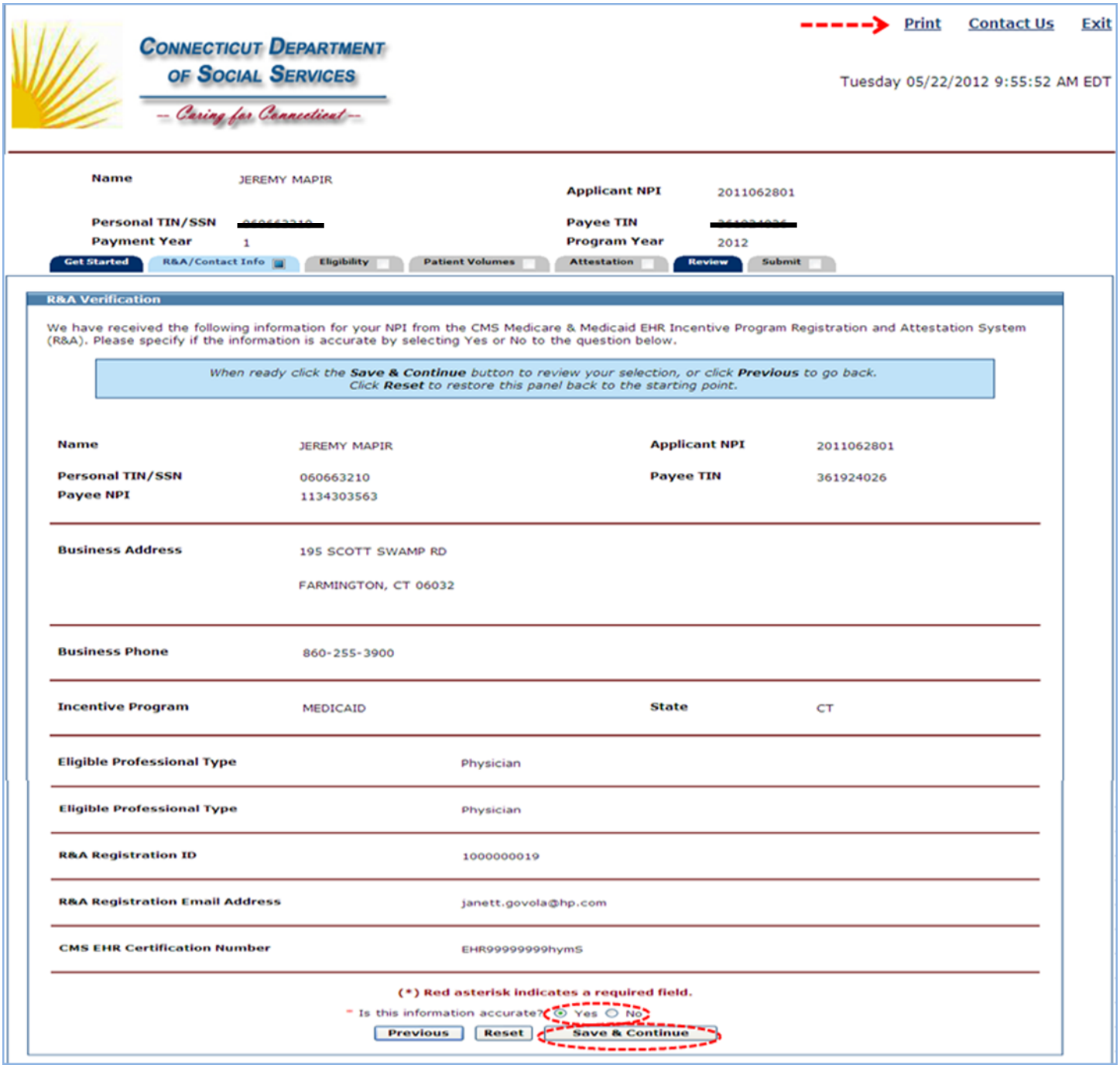
See the Using MAPIR section of this guide for information on using the **Print**, **Contact Us**, and **Exit** links.

Check your information carefully to ensure all of it is accurate.

Compare the R&A Registration ID you received when you registered with the R&A with the **R&A Registration ID** that is displayed.

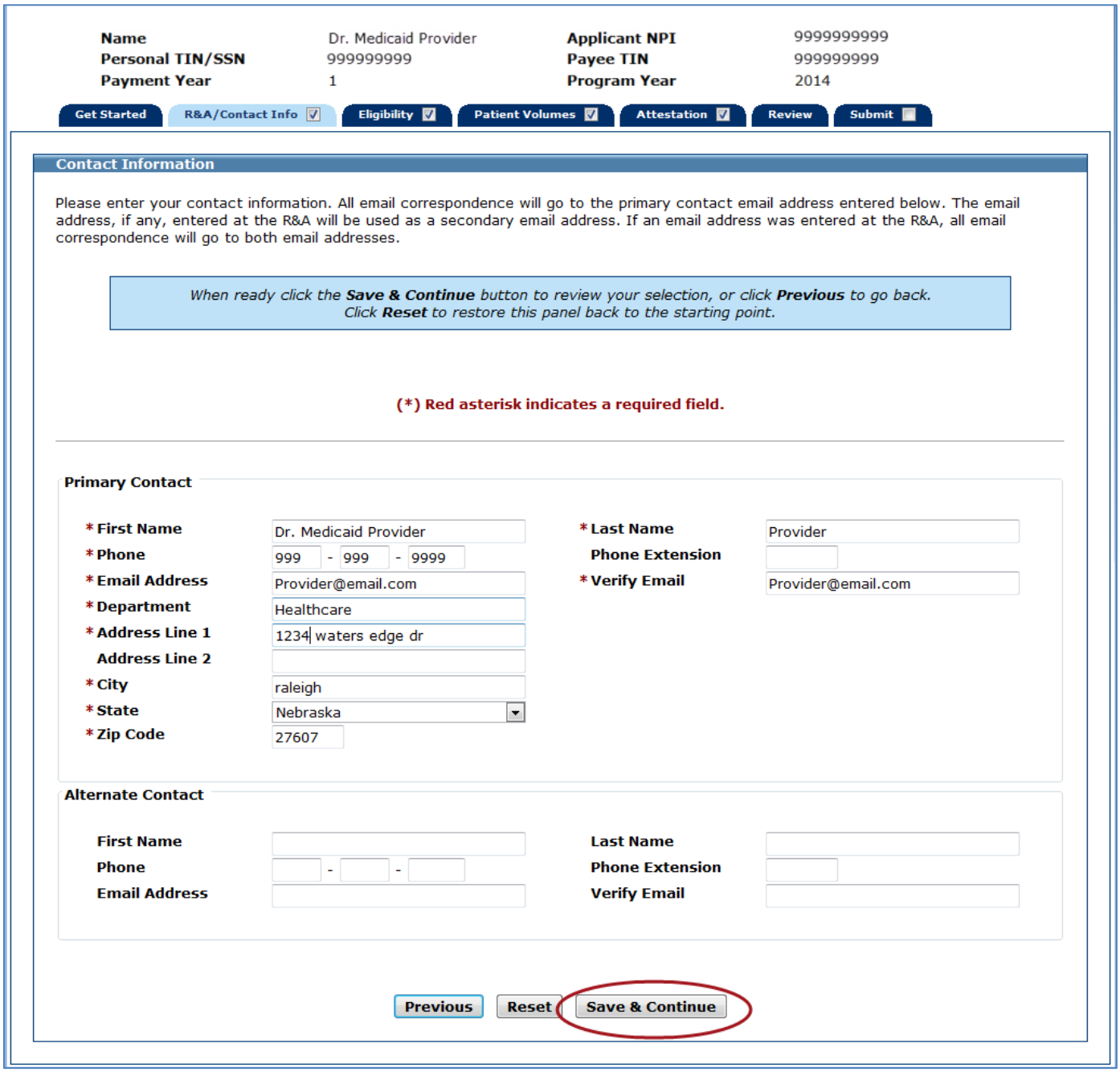
After reviewing the information click **Yes** or **No**.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data. The Reset button will not reset the R&A information. If the R&A information is incorrect, you will need to return to the R&A website to correct it.


Print
Contact Us
Exit
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --
Tuesday 05/22/2012 9:55:52 AM EDT
Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN
Payee TIN
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
R&A Verification
We have received the following information for your NPI from the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A). Please specify if the information is accurate by selecting Yes or No to the question below.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel back to the starting point.
Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN 060663210
Payee TIN 361924026
Payee NPI 1134303563
Business Address 195 SCOTT SWAMP RD
FARMINGTON, CT 06032
Business Phone 860-255-3900
Incentive Program MEDICAID
State CT
Eligible Professional Type Physician
Eligible Professional Type Physician
R&A Registration ID 1000000019
R&A Registration Email Address janett.govola@hp.com
CMS EHR Certification Number EHR99999999hymS
(*) Red asterisk indicates a required field.
* Is this information accurate? Yes No
Previous
Reset
Save & Continue

Enter the required contact information.

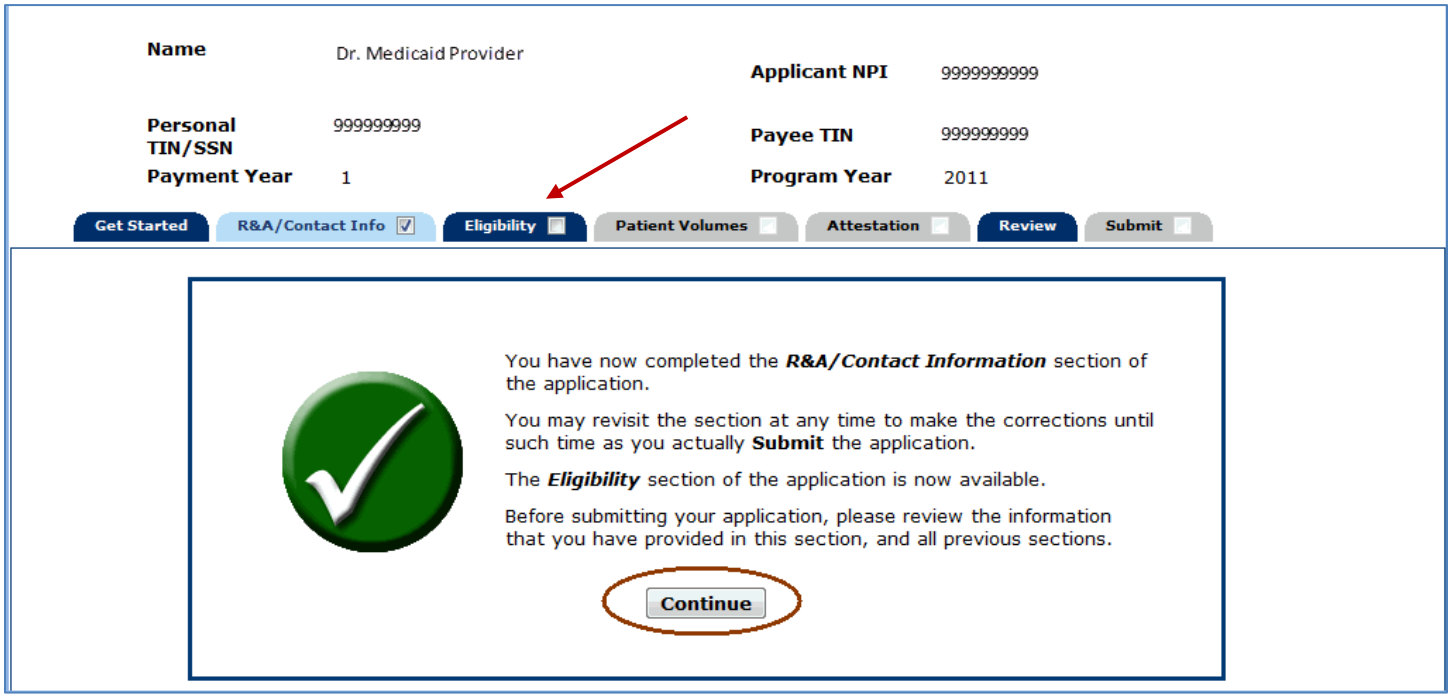
Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.



This screen confirms you successfully completed the **R&A/Contact Info** section.

Note the check box located in the **R&A/Contact Info** tab. You can return to this section to update the Contact Information at any time prior to submitting your application.

Click **Continue** to proceed to the **Eligibility** section.

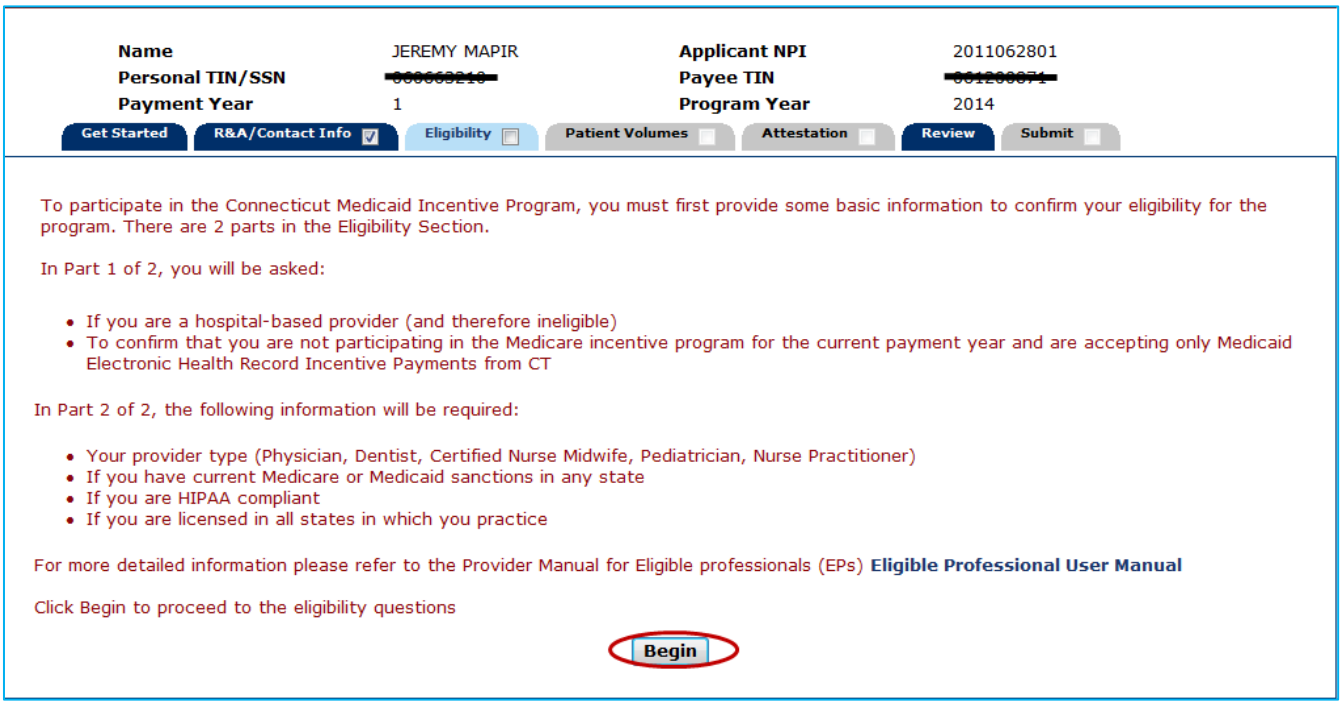


Step 3 – Eligibility

The Eligibility section will ask questions to allow the Connecticut Medicaid program to make a determination regarding your eligibility for the Medicaid EHR Incentive Payment Program. You will also enter your required CMS EHR Certification ID.

The initial **Eligibility** screen contains information about this section.

Click **Begin** to proceed to the **Eligibility Questions (Part 1 of 2).**


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
To participate in the Connecticut Medicaid Incentive Program, you must first provide some basic information to confirm your eligibility for the program. There are 2 parts in the Eligibility Section.
In Part 1 of 2, you will be asked:
If you are a hospital-based provider (and therefore ineligible)
To confirm that you are not participating in the Medicare incentive program for the current payment year and are accepting only Medicaid Electronic Health Record Incentive Payments from CT
In Part 2 of 2, the following information will be required:
Your provider type (Physician, Dentist, Certified Nurse Midwife, Pediatrician, Nurse Practitioner)
If you have current Medicare or Medicaid sanctions in any state
If you are HIPAA compliant
If you are licensed in all states in which you practice
For more detailed information please refer to the Provider Manual for Eligible professionals (EPs) Eligible Professional User Manual
Click Begin to proceed to the eligibility questions
Begin

Select **Yes** or **No** to the eligibility questions.

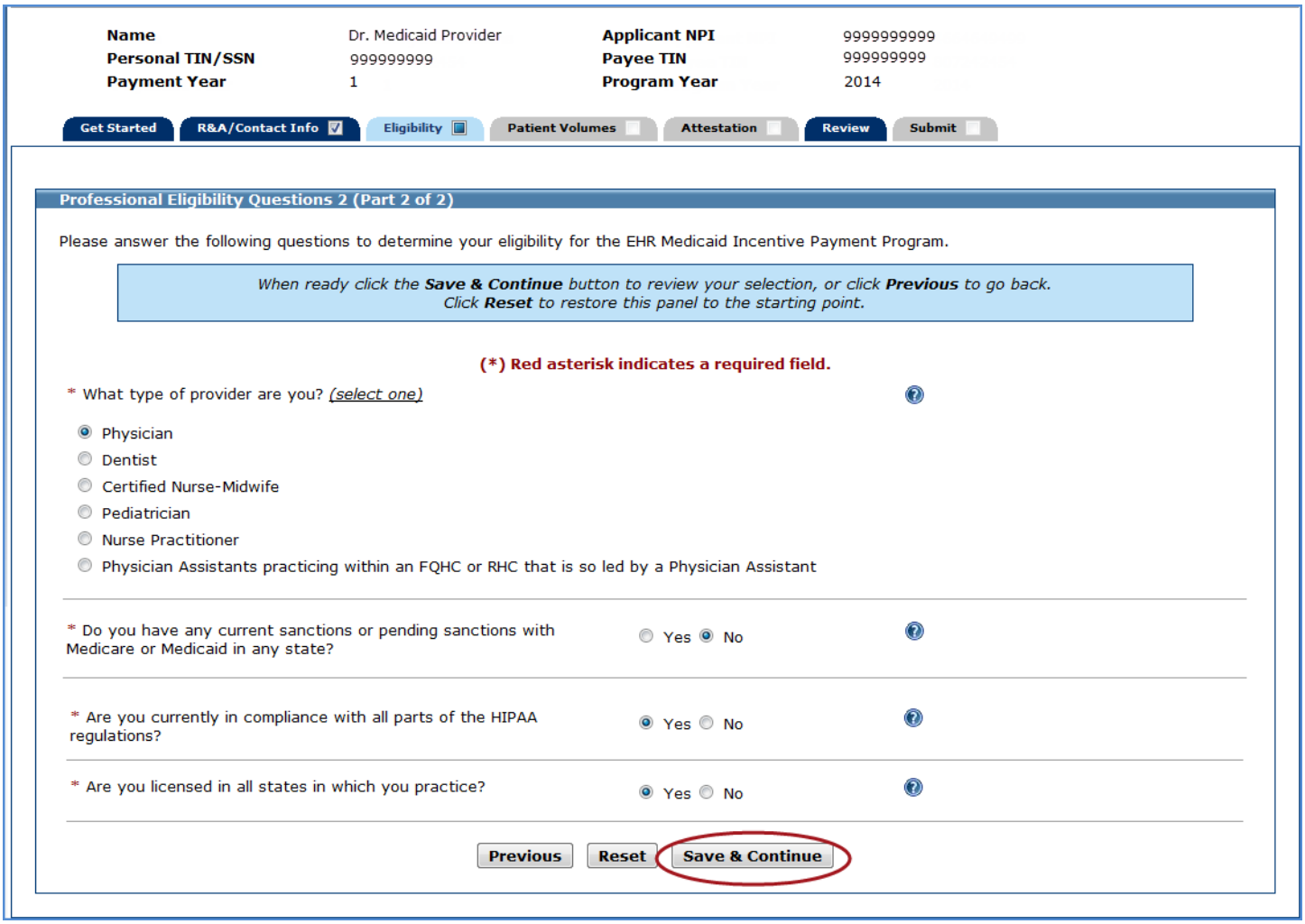
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or the last saved data.

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Professional Eligibility Questions 1 (Part 1 of 2)
Please answer the following questions to determine your eligibility for the EHR Medicaid Incentive Payment Program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Are you a Hospital based eligible professional?
Yes No
* I confirm that I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and am only accepting Medicaid Electronic Health Record Incentive Payments from Colorado?
Yes No
Previous
Reset
Save & Continue

This screen will ask questions to determine your eligibility for the EHR Medicaid Incentive Payment Program. Please select your provider type from the list and answer the questions. This provider type has to match your provider type and specialty on file with Connecticut Medicaid Management Information System (MMIS).

Note: Physician Assistants are eligible to apply for the EHR Incentive Payment only if they practice in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a Physician Assistant. This is not an applicable provider selection for Connecticut.

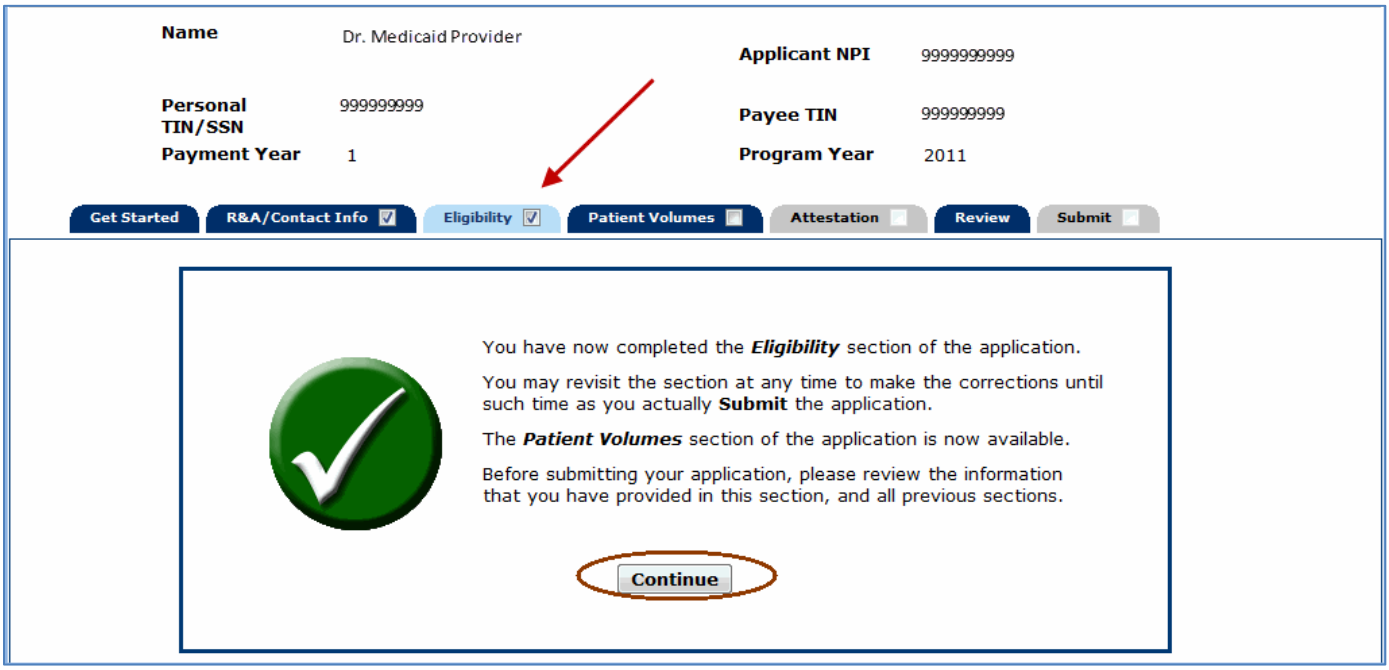
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Professional Eligibility Questions 2 (Part 2 of 2)
Please answer the following questions to determine your eligibility for the EHR Medicaid Incentive Payment Program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* What type of provider are you? (select one)
Physician
Dentist
Certified Nurse-Midwife
Pediatrician
Nurse Practitioner
Physician Assistants practicing within an FQHC or RHC that is so led by a Physician Assistant
* Do you have any current sanctions or pending sanctions with Medicare or Medicaid in any state?
Yes
No
* Are you currently in compliance with all parts of the HIPAA regulations?
Yes
No
* Are you licensed in all states in which you practice?
Yes
No
Previous
Reset
Save & Continue

This screen confirms you successfully completed the **Eligibility** section.

Note the check box in the **Eligibility** tab.

Click **Continue** to proceed to the **Patient Volumes** section.



Step 4 - Patient Volumes

The Patient Volumes section gathers information about your practice type, practice locations, the 90 day period you intend to use for reporting the patient volumes, and the patient volumes themselves. Additionally, you will be asked about how you utilize your certified EHR technology.

There are three parts to Patient Volumes:

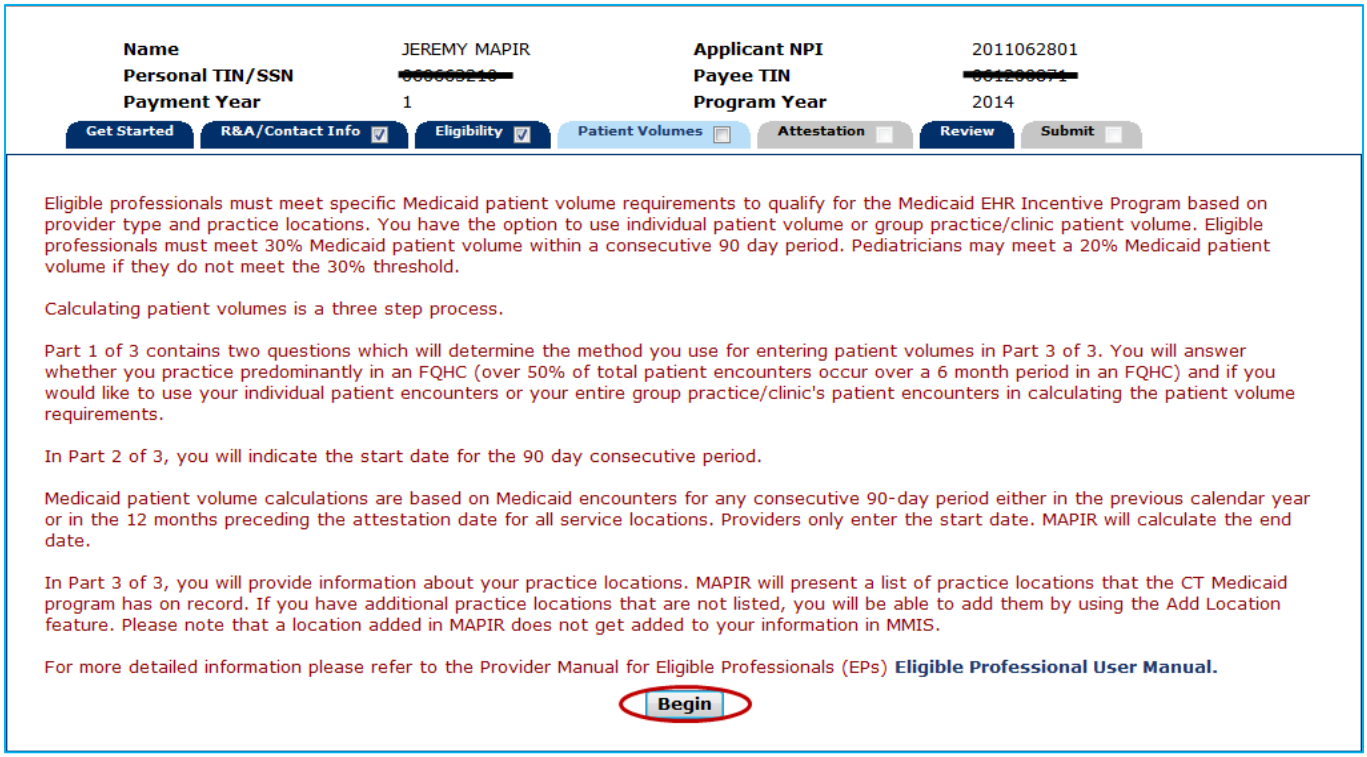
Part 1 of 3 contains two questions which will determine the method you use for entering patient volumes in Part 3 of 3.

Part 2 of 3 establishes the 90 day period for reporting patient volumes.

Part 3 of 3 contains screens to add new locations for reporting **Medicaid Patient Volumes,** selecting at least one location for **Utilizing Certified EHR Technology**, and entering patient volumes for the chosen reporting period.

The initial **Patient Volumes** screen contains information about this section.

Click **Begin** to proceed to the **Patient Volume Practice Type (Part 1 of 3)** screen.

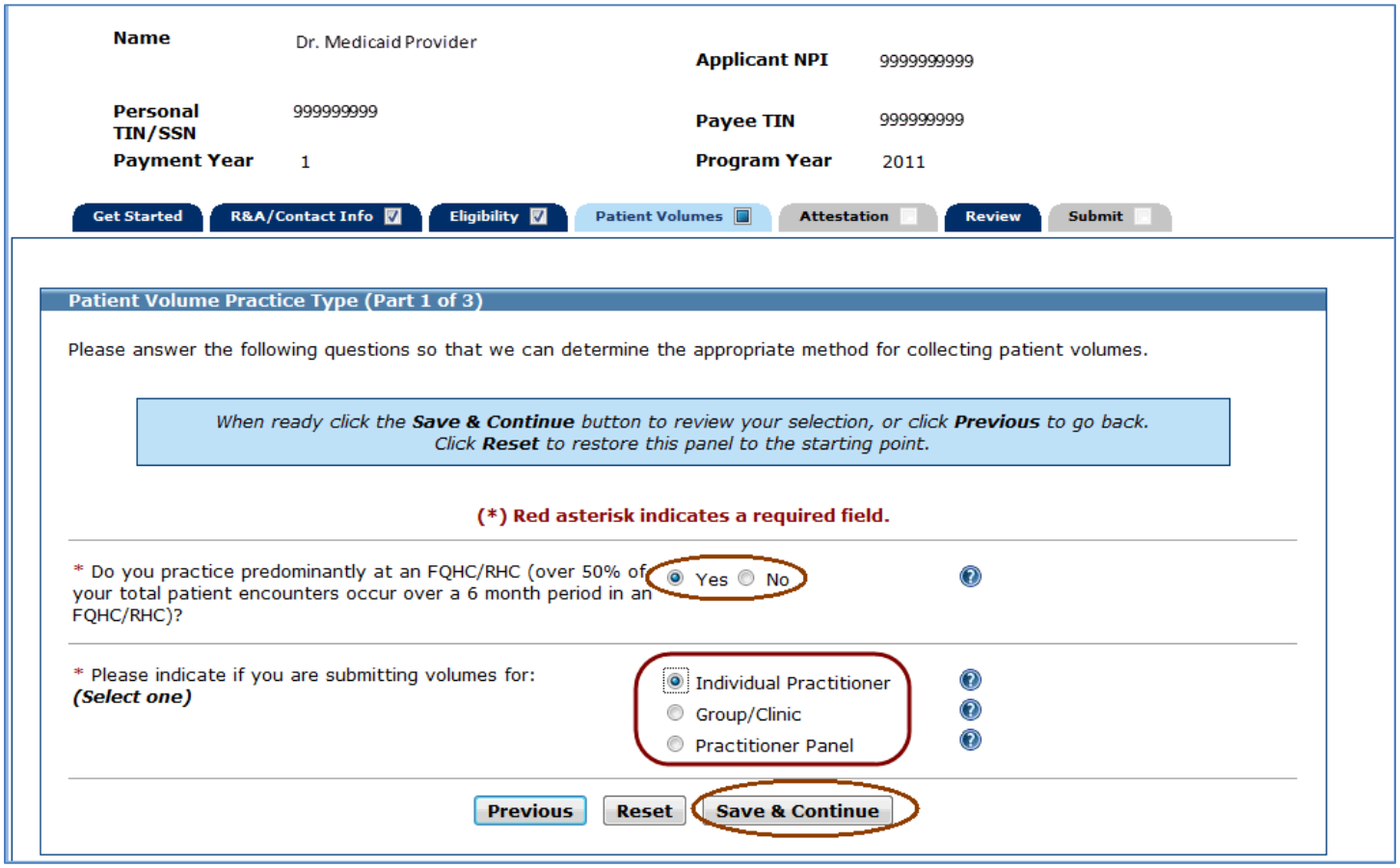

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Eligible professionals must meet specific Medicaid patient volume requirements to qualify for the Medicaid EHR Incentive Program based on provider type and practice locations. You have the option to use individual patient volume or group practice/clinic patient volume. Eligible professionals must meet 30% Medicaid patient volume within a consecutive 90 day period. Pediatricians may meet a 20% Medicaid patient volume if they do not meet the 30% threshold.
Calculating patient volumes is a three step process.
Part 1 of 3 contains two questions which will determine the method you use for entering patient volumes in Part 3 of 3. You will answer whether you practice predominantly in an FQHC (over 50% of total patient encounters occur over a 6 month period in an FQHC) and if you would like to use your individual patient encounters or your entire group practice/clinic's patient encounters in calculating the patient volume requirements.
In Part 2 of 3, you will indicate the start date for the 90 day consecutive period.
Medicaid patient volume calculations are based on Medicaid encounters for any consecutive 90-day period either in the previous calendar year or in the 12 months preceding the attestation date for all service locations. Providers only enter the start date. MAPIR will calculate the end date.
In Part 3 of 3, you will provide information about your practice locations. MAPIR will present a list of practice locations that the CT Medicaid program has on record. If you have additional practice locations that are not listed, you will be able to add them by using the Add Location feature. Please note that a location added in MAPIR does not get added to your information in MMIS.
For more detailed information please refer to the Provider Manual for Eligible Professionals (EPs) Eligible Professional User Manual.
Begin

Patient Volume Practice Type (Part 1 of 3)

Patient Volume Practice Type (Part 1 of 3) contains two questions about your practice type to determine the appropriate method for collecting patient volume information.

Select the appropriate answers using the buttons. Move your cursor over the to access additional information.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.



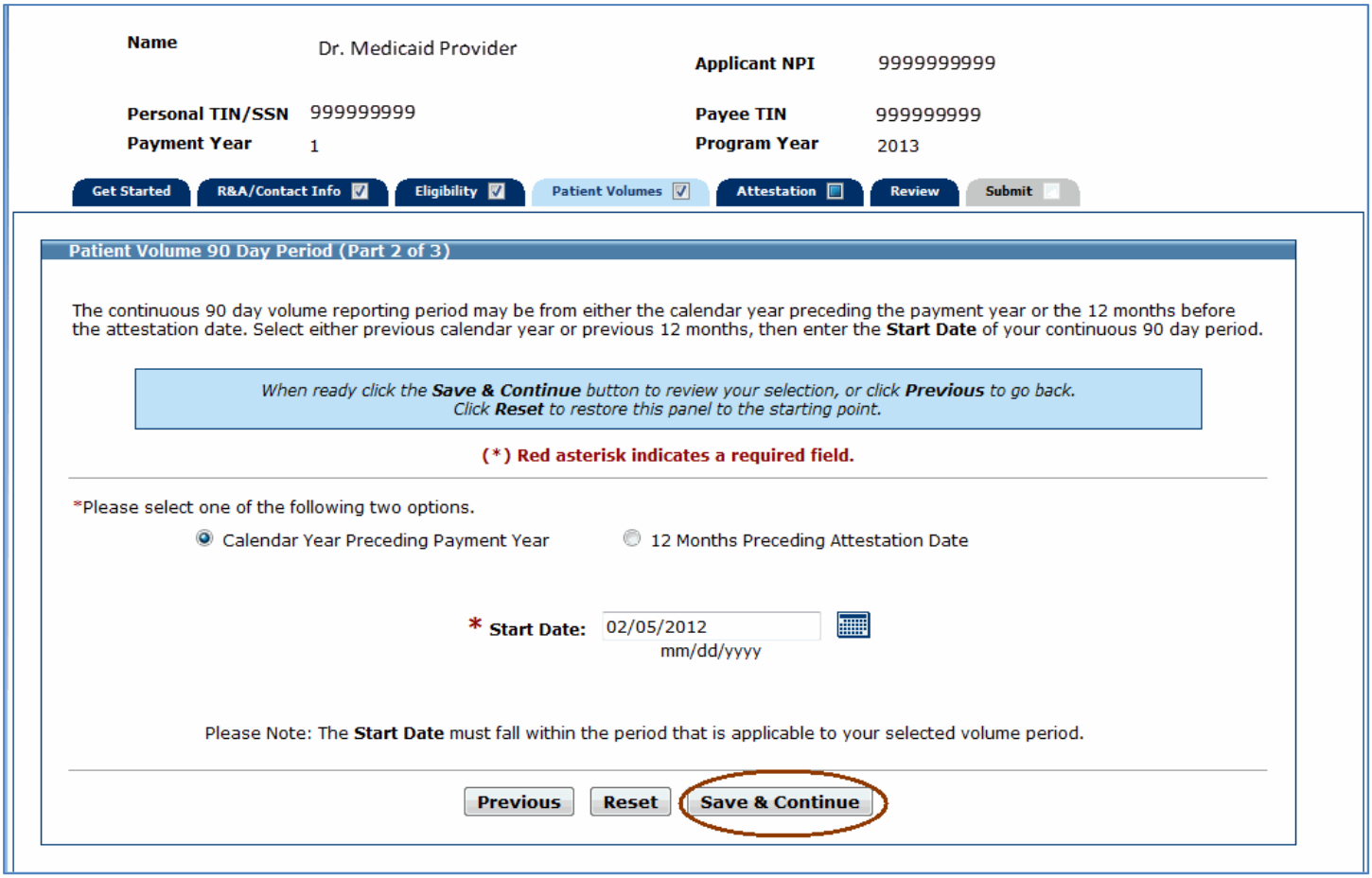
Patient Volume 90 Day Period (Part 2 of 3)

For all practice types MAPIR will ask you to enter the start date of the 90 day patient volume reporting period in which you will demonstrate the required Medicaid patient volume participation level.

Select if you would like your 90 day patient volume reporting period to be from either the **Calendar Year Preceding the Payment Year** or the **12 Months Preceding Attestation Date**.

Enter a **Start Date** or select one from the calendar icon located to the right of the Start Date field.

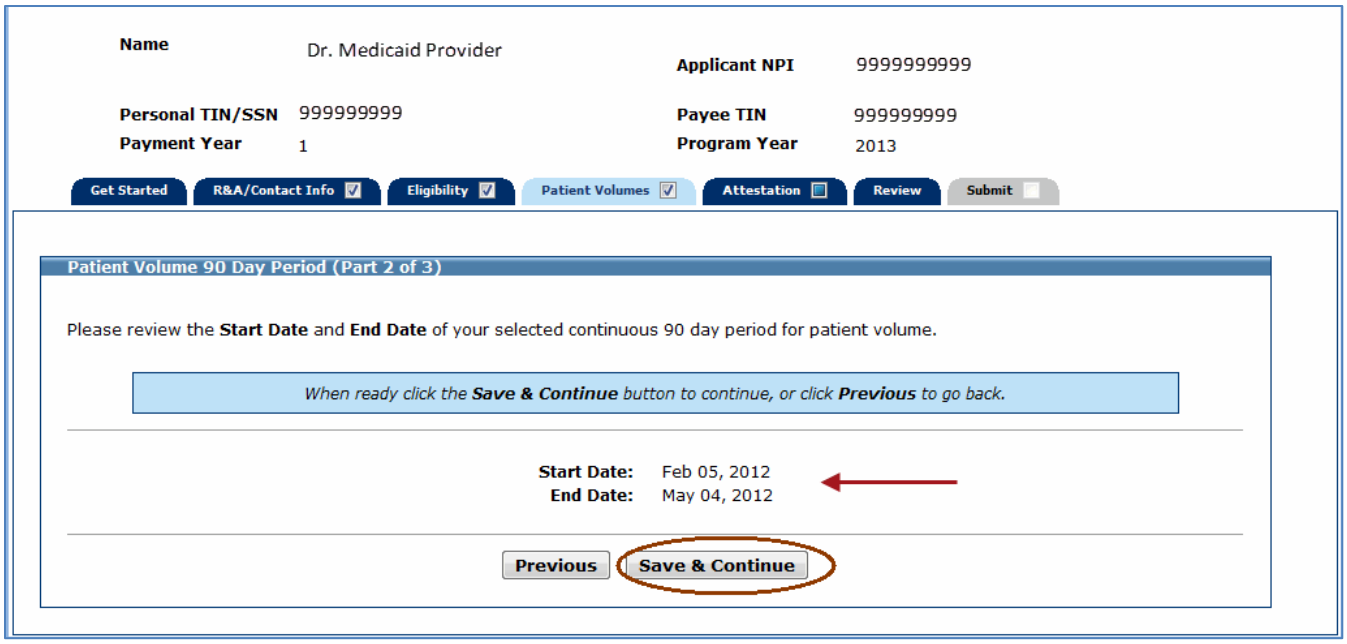
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume 90 Day Period (Part 2 of 3)
The continuous 90 day volume reporting period may be from either the calendar year preceding the payment year or the 12 months before the attestation date. Select either previous calendar year or previous 12 months, then enter the Start Date of your continuous 90 day period.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Please select one of the following two options.
Calendar Year Preceding Payment Year
12 Months Preceding Attestation Date
* Start Date:
02/05/2012
mm/dd/yyyy
Please Note: The Start Date must fall within the period that is applicable to your selected volume period.
Previous
Reset
Save & Continue

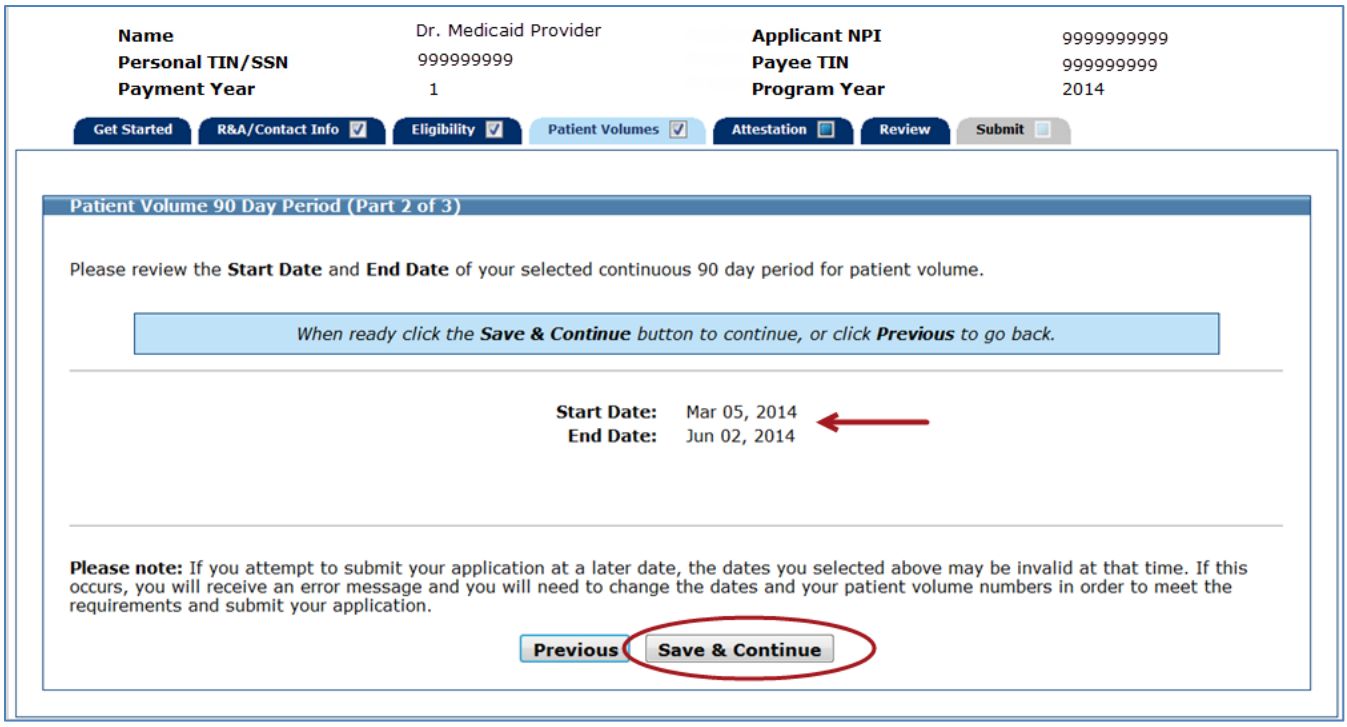
Review the **Start Date** and **End Date** information. The 90 Day **End Date** has been calculated for you.

Click **Save & Continue** to continue, or click **Previous** to go back.

Screen for Calendar Year Preceding Payment Year.



Screen for 12 Months Preceding Attestation Date.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume 90 Day Period (Part 2 of 3)
Please review the Start Date and End Date of your selected continuous 90 day period for patient volume.
When ready click the Save & Continue button to continue, or click Previous to go back.
Start Date:
Mar 05, 2014
End Date:
Jun 02, 2014
Please note: If you attempt to submit your application at a later date, the dates you selected above may be invalid at that time. If this occurs, you will receive an error message and you will need to change the dates and your patient volume numbers in order to meet the requirements and submit your application.
Previous
Save & Continue

Patient Volume (Part 3 of 3)

In order to meet the requirements of the Medicaid EHR Incentive Program you must provide information about your patient volumes. The information will be used to determine your eligibility for the incentive program. The responses to the questions for Practice Type (Part 1 of 3) on the first Patient Volume screen determine the questions you will be asked to complete and the information required. The information is summarized below:

1. Practice locations – MAPIR will present a list of practice locations that Connecticut Medicaid program office has on record. If you have additional practice locations you have the option to add them. When all locations are added, you will enter the required information for all your practice locations.
2. Utilizing Certified EHR Technology – You must select the practice locations where you are utilizing certified EHR technology. At least one practice location must be selected.
3. Patient volume – You are required to enter the information for the patient volume 90 day period you entered.

Depending on your practice type you will be asked for different information related to patient volumes. Not all information you enter will be used in the patient volume percentage calculation. Information not used will be reviewed by Connecticut Medicaid program to assist with determining your eligibility. The specific formula for each practice type percentage calculation is listed within the section for that practice type.

The table below directs you to the page number in this guide to provide details for completing this section.

Practice Type	Page No.
Individual	40
Group	46
FQHC/RHC* Individual	52
FQHC/RHC* Group	58

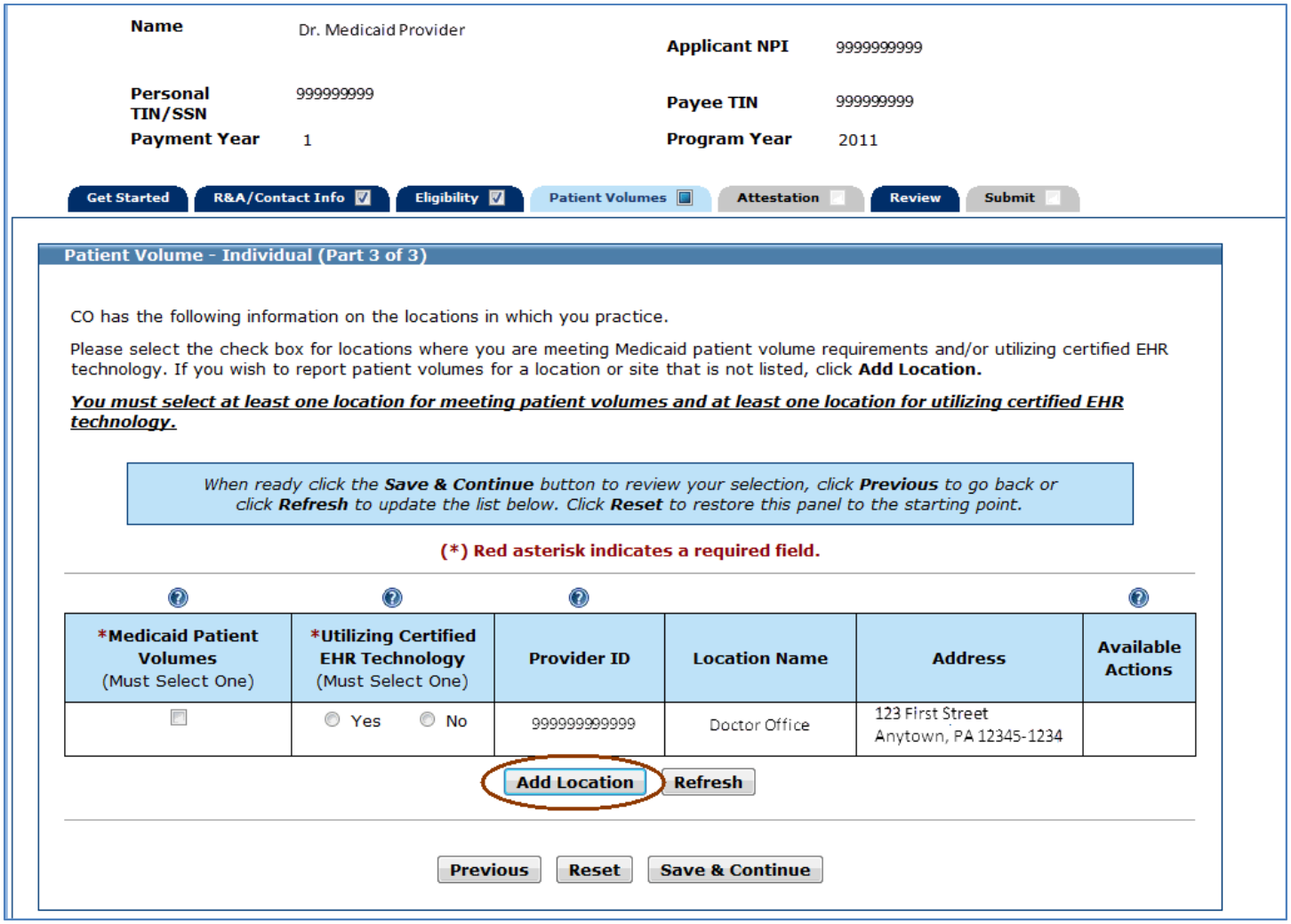
* Federally Qualified Health Center/Rural Health Clinic

Patient Volume – Individual

The following pages will show you how to apply for the EHR Incentive program as an Individual provider. If you are not applying as an Individual provider, refer to the table on page 39 for more information about your practice type.

Practice locations – MAPIR will present a list of locations that Connecticut Medicaid program office has on record. If you have additional locations, you can add them. Once all locations are added, you will enter the required Patient Volume information.

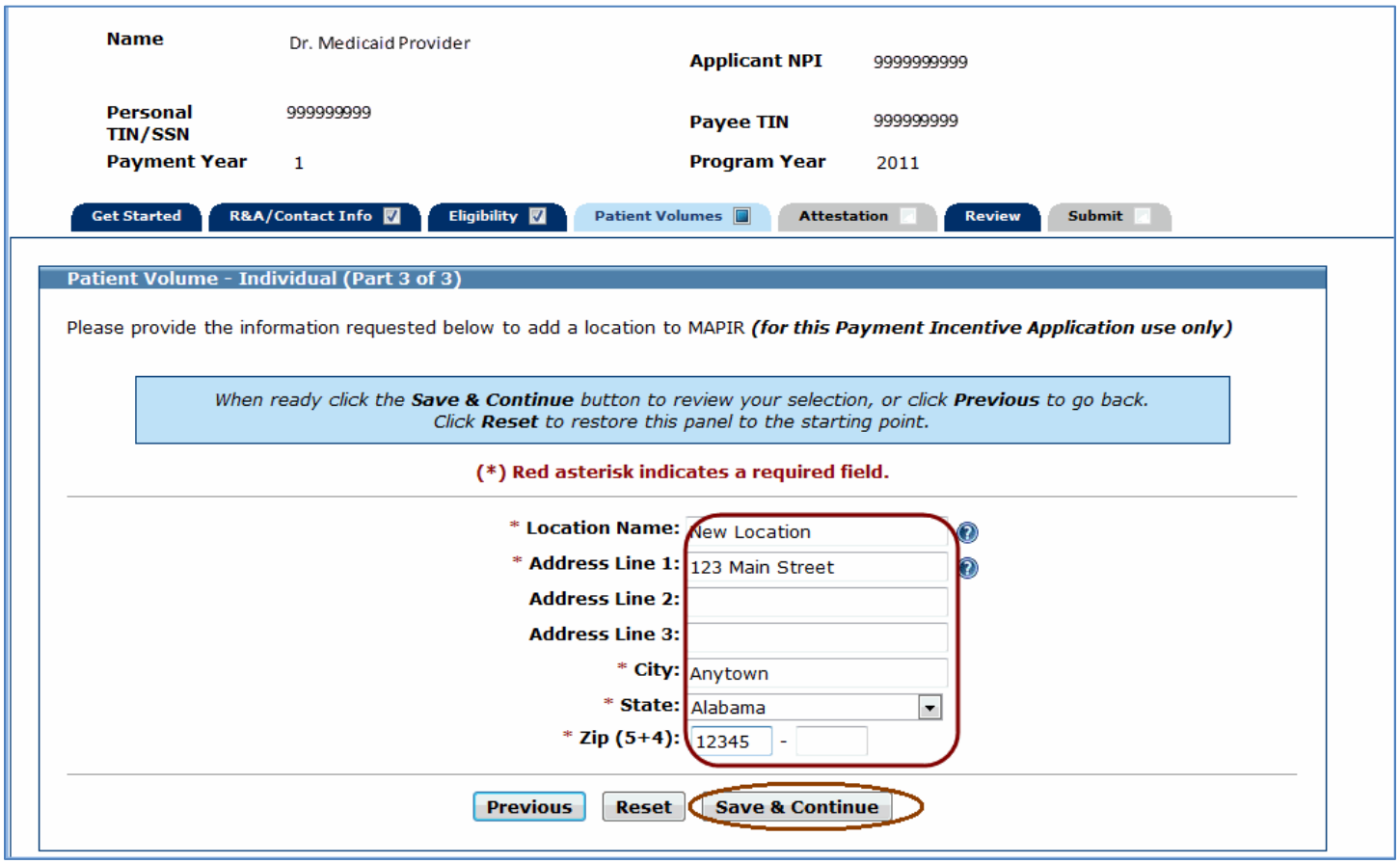
Add new locations by clicking **Add Location**.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - Individual (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Medicaid Patient Volumes (Must Select One)
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street
Anytown, PA 12345-1234
Add Location
Refresh
Previous
Reset
Save & Continue

If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested practice location information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.



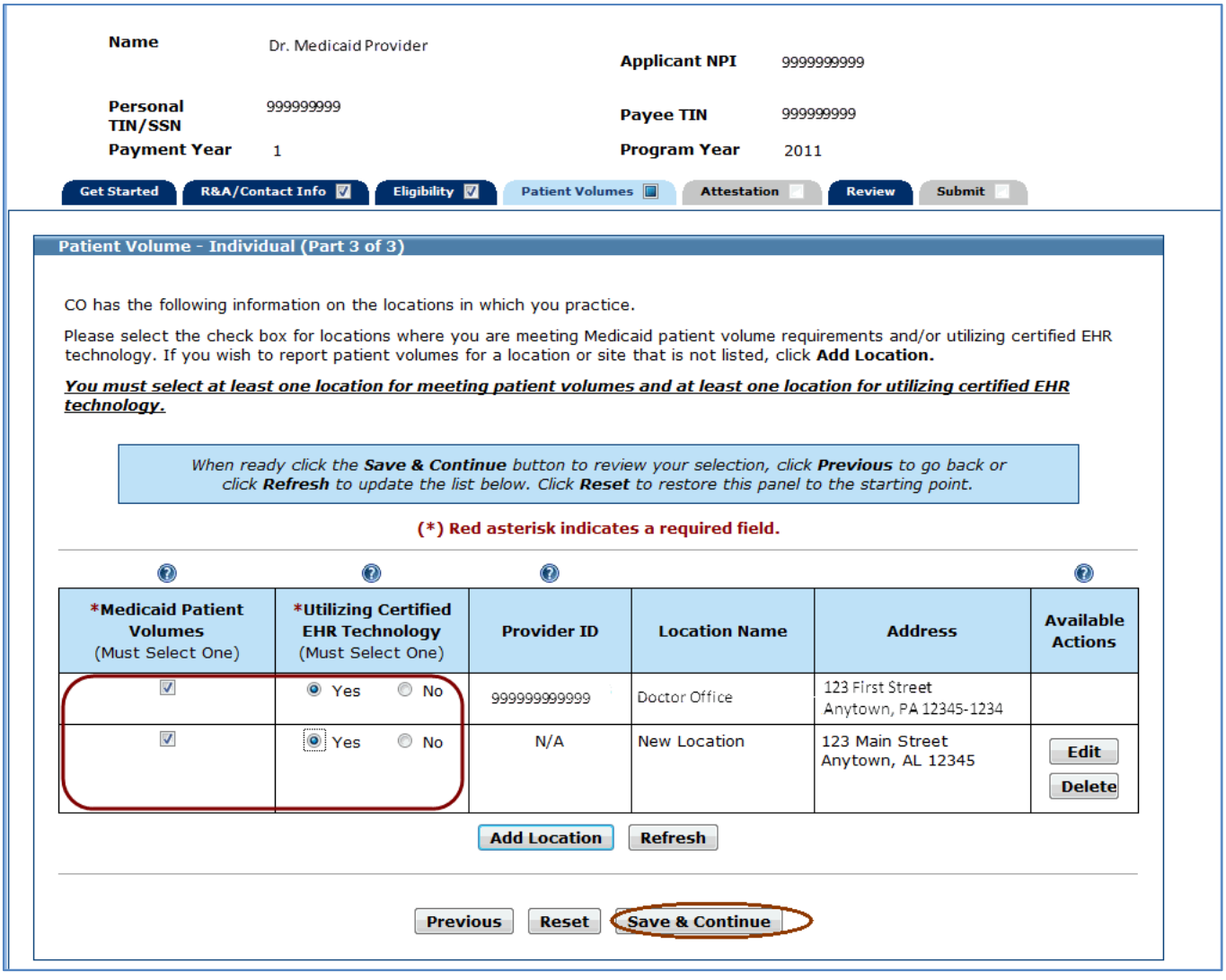
For each location, check whether you will report **Medicaid Patient Volumes** and whether you plan to **Utilize Certified EHR Technology**. You must select at least one location for meeting patient requirements and at least one location for utilizing certified EHR technology.

*Note: For every location listed on this screen, even if you did not select it as a location to meet patient requirements (**Medicaid Patient Volume** column), you must indicate if you are using certified EHR technology at this location by selecting Yes or No in the **Utilizing Certified EHR Technology** column.*

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - Individual (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Medicaid Patient Volumes (Must Select One)
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street Anytown, PA 12345-1234
Yes
No
N/A
New Location
123 Main Street Anytown, AL 12345
Edit
Delete
Add Location
Refresh
Previous
Reset
Save & Continue

Click **Begin** to proceed to the screens where you will enter patient volumes.

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
You will now enter patient encounter volumes for the 90 day period you selected.
Medicaid encounters are defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program (both in-state and out-of-state). Total encounter volume counts encounters for all patients regardless of health insurance coverage.
Medicaid Patient Volume Percentage Formula:
Medicaid Encounter Volume / Total Encounter Volume
The final panel in Part 3 of 3 of Patient Volumes will reflect all of the information you entered for your practice location(s), patient encounters and certified EHR technology use. MAPIR calculates and displays your Medicaid encounter percentage. At least one practice location must meet Medicaid Patient Volumes and be utilizing Certified EHR Technology.
For more detailed information please refer to the Provider Manual for Eligible Professionals (EPs) Eligible Professional User Manual
Begin

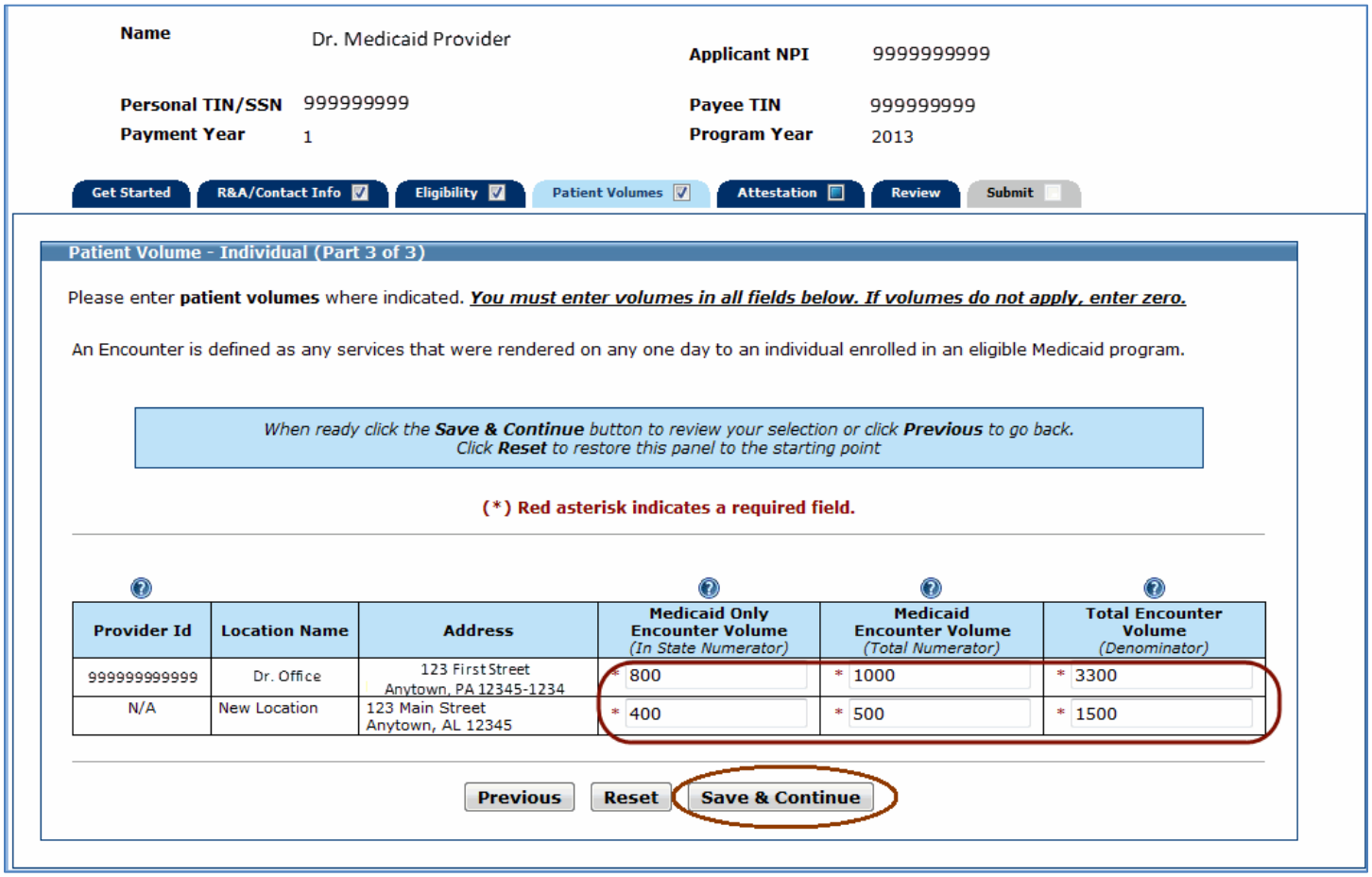
The following formula is used to calculate the Patient Volume when the individual practitioner submits his/her own patient volumes:

Medicaid Patient Volume Percentage Formula - Individual

(Medicaid Encounter Volume / Total Encounter Volume)

Enter patient volumes for each location listed. Medicaid encounter is defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

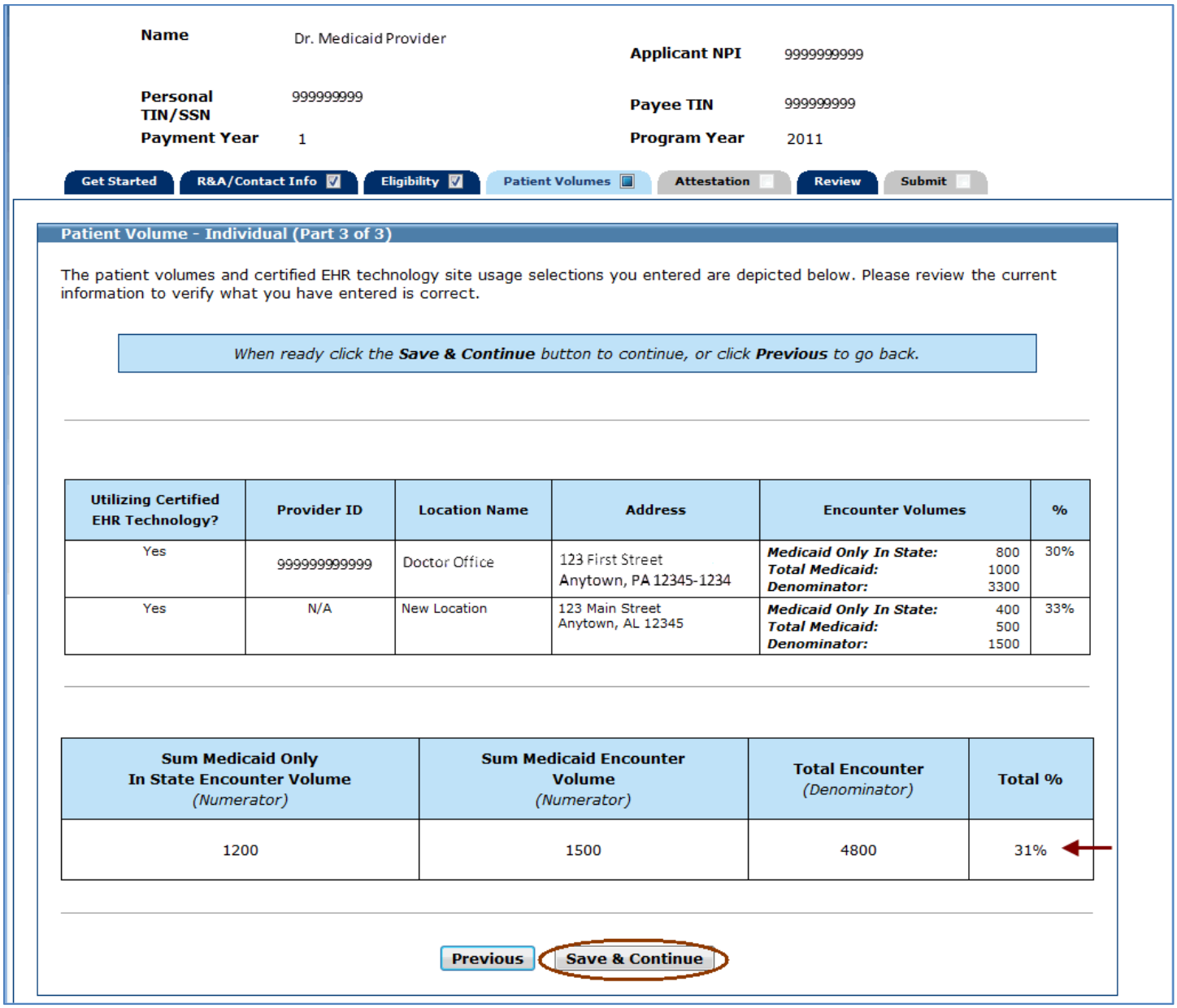


After selecting **Save & Continue** this panel will be updated with the locations where you are utilizing certified EHR technology, patient volumes you entered, all values summarized, and the Medicaid patient volume percentage. Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement. Pediatricians who do not meet the 30% Medicaid patient volume but meet the 20% Medicaid patient volume, will not receive the full incentive payment amount.

Click **Save & Continue** to proceed or **Previous** to go back.

Proceed to page 64 of this guide to continue with the application.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2011

Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Patient Volume - Individual (Part 3 of 3)

The patient volumes and certified EHR technology site usage selections you entered are depicted below. Please review the current information to verify what you have entered is correct.

*When ready click the **Save & Continue** button to continue, or click **Previous** to go back.*

Utilizing Certified EHR Technology?	Provider ID	Location Name	Address	Encounter Volumes		%
Yes	999999999999	Doctor Office	123 First Street Anytown, PA 12345-1234	***Medicaid Only In State:*** ***Total Medicaid:*** ***Denominator:***	800 1000 3300	30%
Yes	N/A	New Location	123 Main Street Anytown, AL 12345	***Medicaid Only In State:*** ***Total Medicaid:*** ***Denominator:***	400 500 1500	33%

Sum Medicaid Only In State Encounter Volume *(Numerator)*	Sum Medicaid Encounter Volume *(Numerator)*	Total Encounter *(Denominator)*	Total %
1200	1500	4800	31%

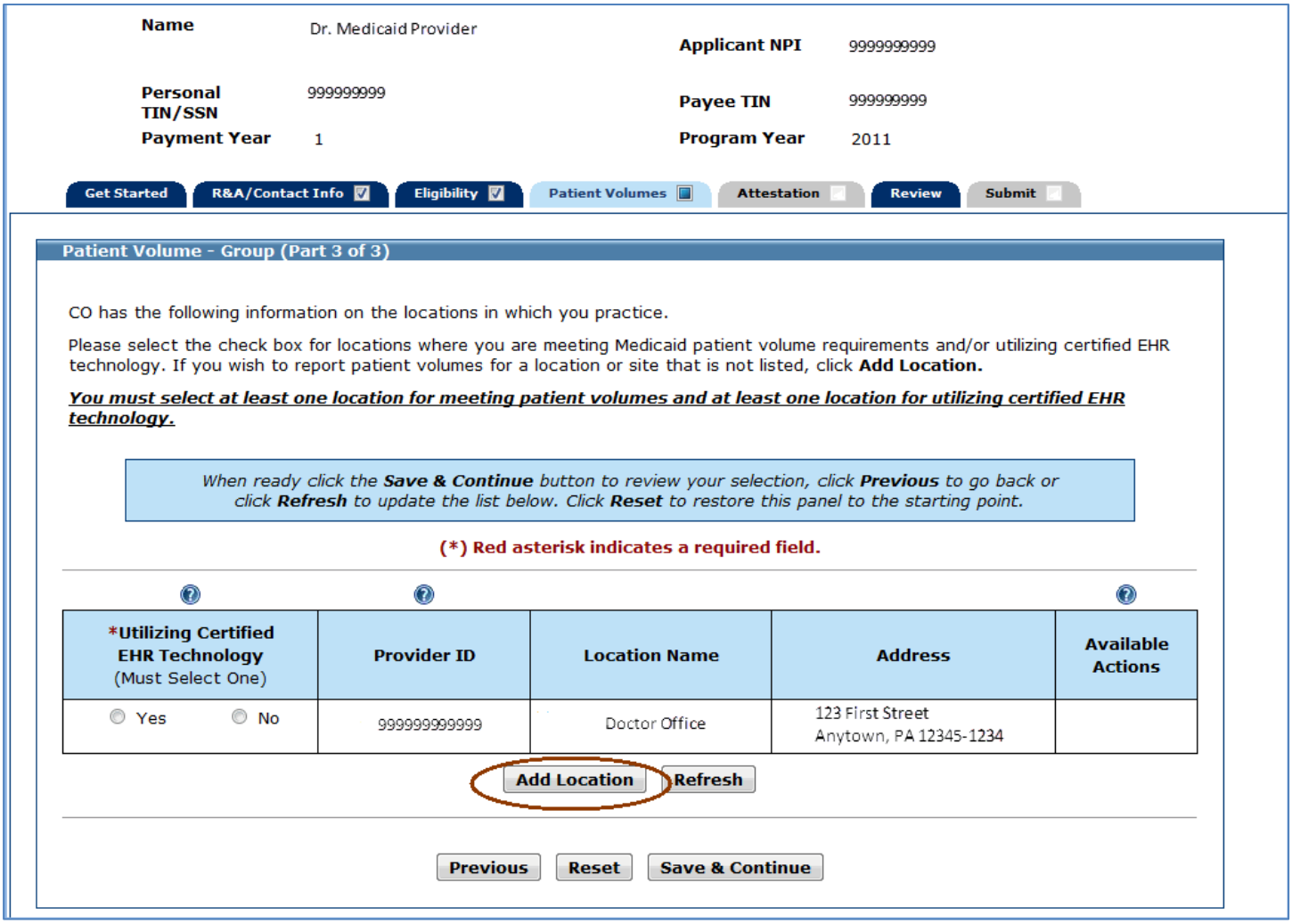
Previous | Save & Continue

Patient Volume – Group

The following pages will show you how to apply for the EHR Incentive program as a Group provider. If you are not applying as a Group provider, refer to the table on page 39 for more information.

Practice locations – MAPIR will present a list of locations that Connecticut Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information. If you do not have any locations to add, you can Click **Save & Continue** to continue to the next section.

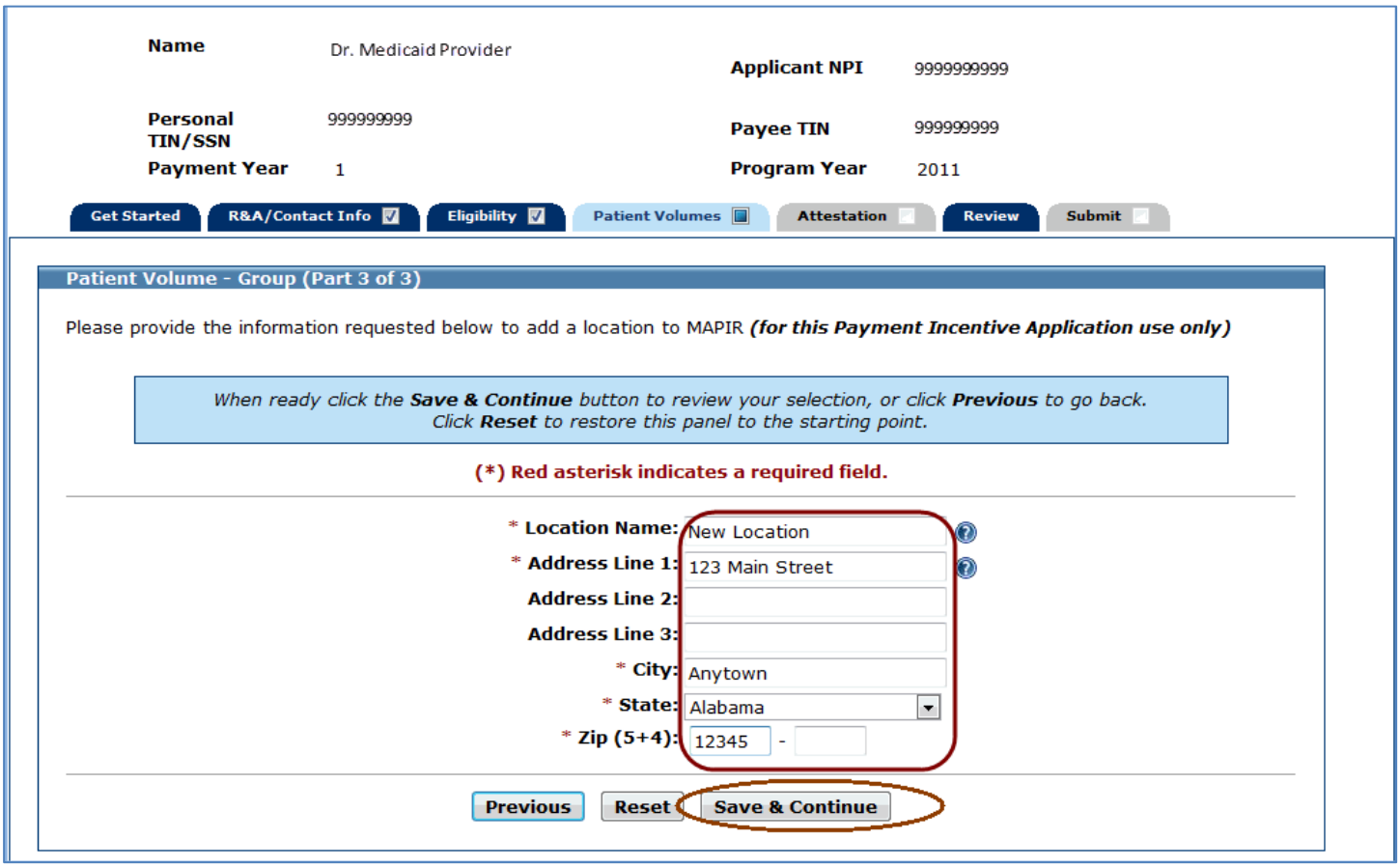
Review the listed locations. Add new locations by clicking **Add Location**.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - Group (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street
Anytown, PA 12345-1234
Add Location
Refresh
Previous
Reset
Save & Continue

If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested practice location information.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



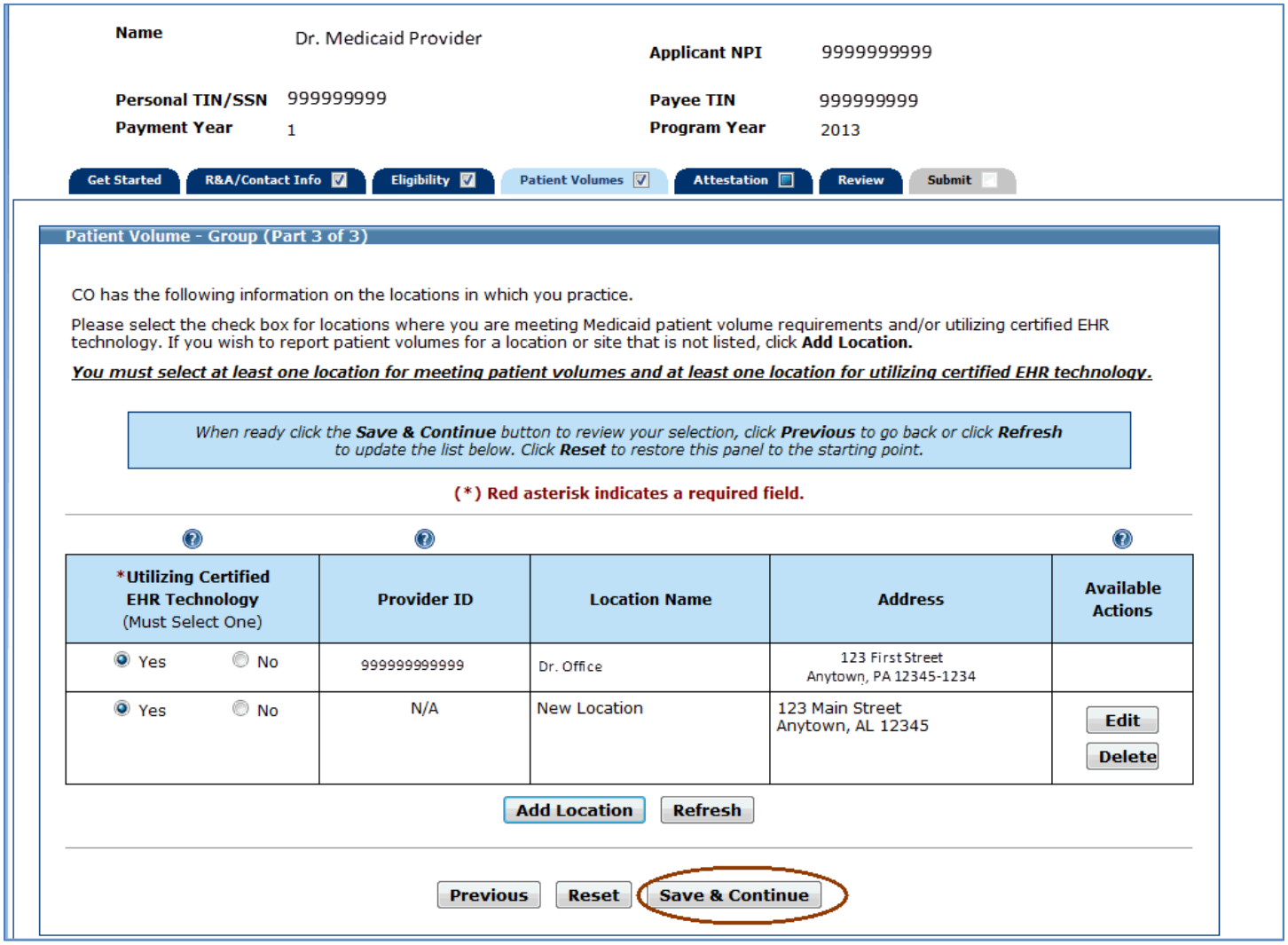
For each location check whether you are **Utilizing Certified EHR Technology**.

*Note: You must indicate if you are using certified EHR technology at every location listed on this screen by selecting Yes or No in the **Utilizing Certified EHR Technology** column.*

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

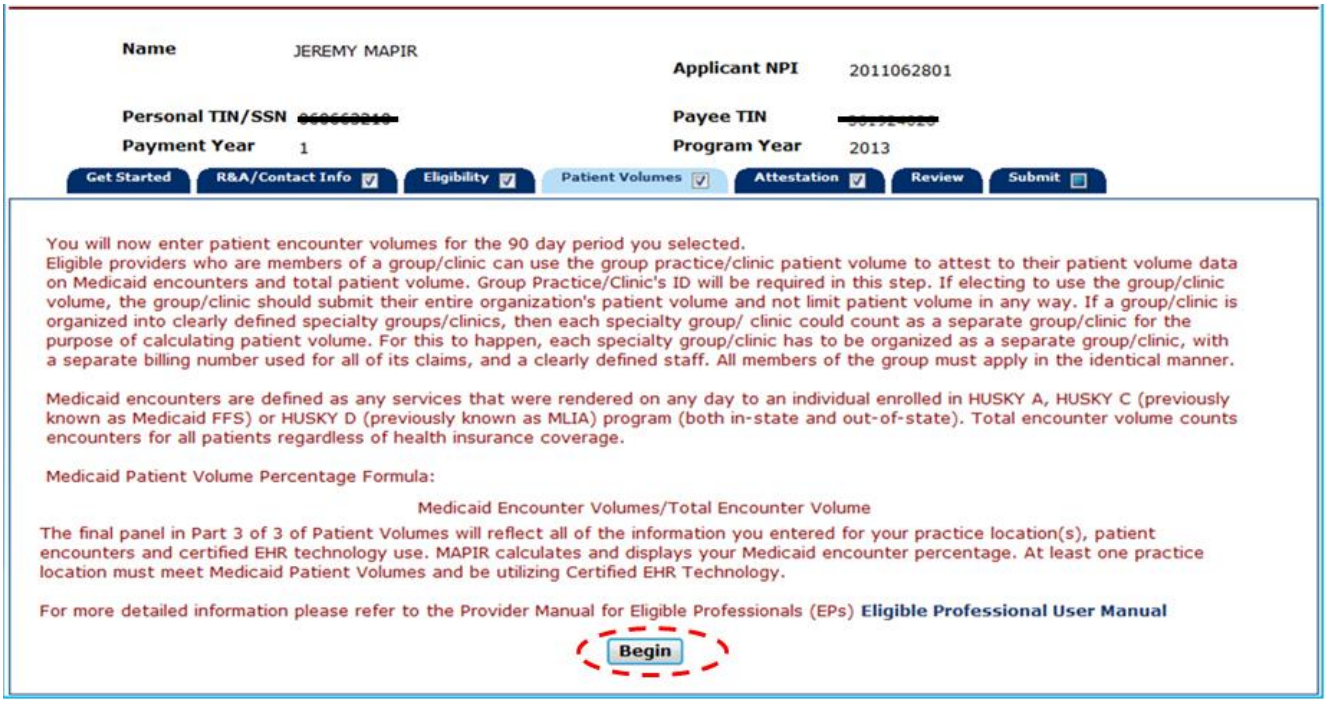
*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - Group (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Dr. Office
123 First Street Anytown, PA 12345-1234
Yes
No
N/A
New Location
123 Main Street Anytown, AL 12345
Edit
Delete
Add Location
Refresh
Previous
Reset
Save & Continue

This screen gives details about the definition of a group/clinic and the encounter data that would qualify towards patient volume. If electing to use the group/clinic volume, the group/clinic should submit their entire organization's patient volume and not limit patient volume in any way. If a group/clinic is organized into clearly defined specialty groups/clinics, then each specialty group/ clinic could count as a separate group/clinic for the purpose of calculating patient volume. For this to happen, each specialty group/clinic has to be organized as a separate group/clinic, with a separate billing number used for all of its claims, and a clearly defined staff.

Click **Begin** to proceed to the screens where you will enter patient volumes.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
You will now enter patient encounter volumes for the 90 day period you selected.
Eligible providers who are members of a group/clinic can use the group practice/clinic patient volume to attest to their patient volume data on Medicaid encounters and total patient volume. Group Practice/Clinic's ID will be required in this step. If electing to use the group/clinic volume, the group/clinic should submit their entire organization's patient volume and not limit patient volume in any way. If a group/clinic is organized into clearly defined specialty groups/clinics, then each specialty group/ clinic could count as a separate group/clinic for the purpose of calculating patient volume. For this to happen, each specialty group/clinic has to be organized as a separate group/clinic, with a separate billing number used for all of its claims, and a clearly defined staff. All members of the group must apply in the identical manner.
Medicaid encounters are defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program (both in-state and out-of-state). Total encounter volume counts encounters for all patients regardless of health insurance coverage.
Medicaid Patient Volume Percentage Formula:
Medicaid Encounter Volumes/Total Encounter Volume
The final panel in Part 3 of 3 of Patient Volumes will reflect all of the information you entered for your practice location(s), patient encounters and certified EHR technology use. MAPIR calculates and displays your Medicaid encounter percentage. At least one practice location must meet Medicaid Patient Volumes and be utilizing Certified EHR Technology.
For more detailed information please refer to the Provider Manual for Eligible Professionals (EPs) Eligible Professional User Manual
Begin

The following formula is used to calculate the Patient Volume when the individual practitioner submits patient volumes for the group as a proxy for his/her own patient volume:

Medicaid Patient Volume Percentage Formula - Group

Medicaid Encounter Volumes

Divided by

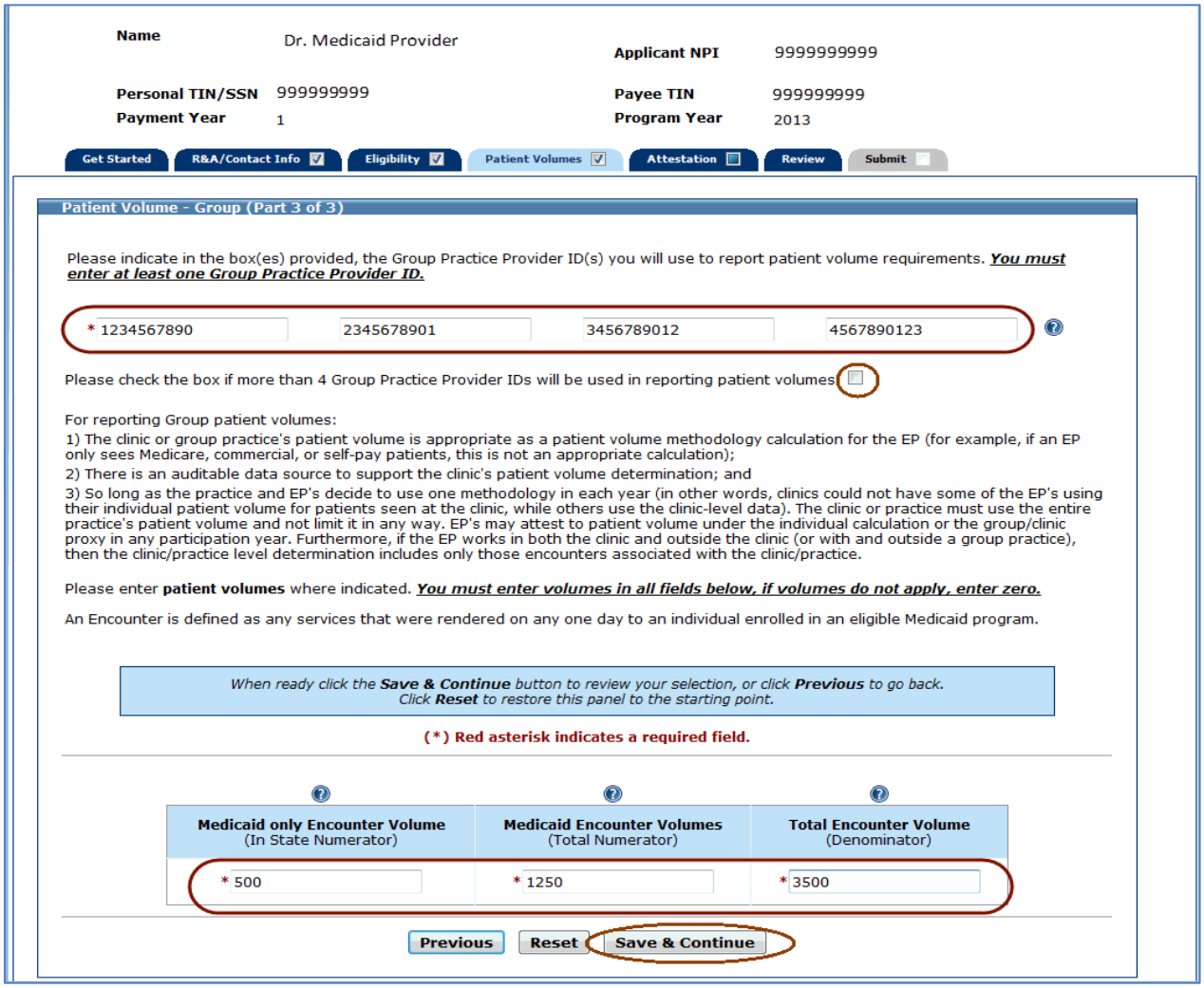
Total Encounter Volume

Enter **Group Practice Provider IDs.**

If you listed four **Group Practice Provider IDs** and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs. **You will be required to upload the documentation for all additional group NPI numbers and provider names in MAPIR**.

Enter patient volumes for each location listed. Medicaid encounter is defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.

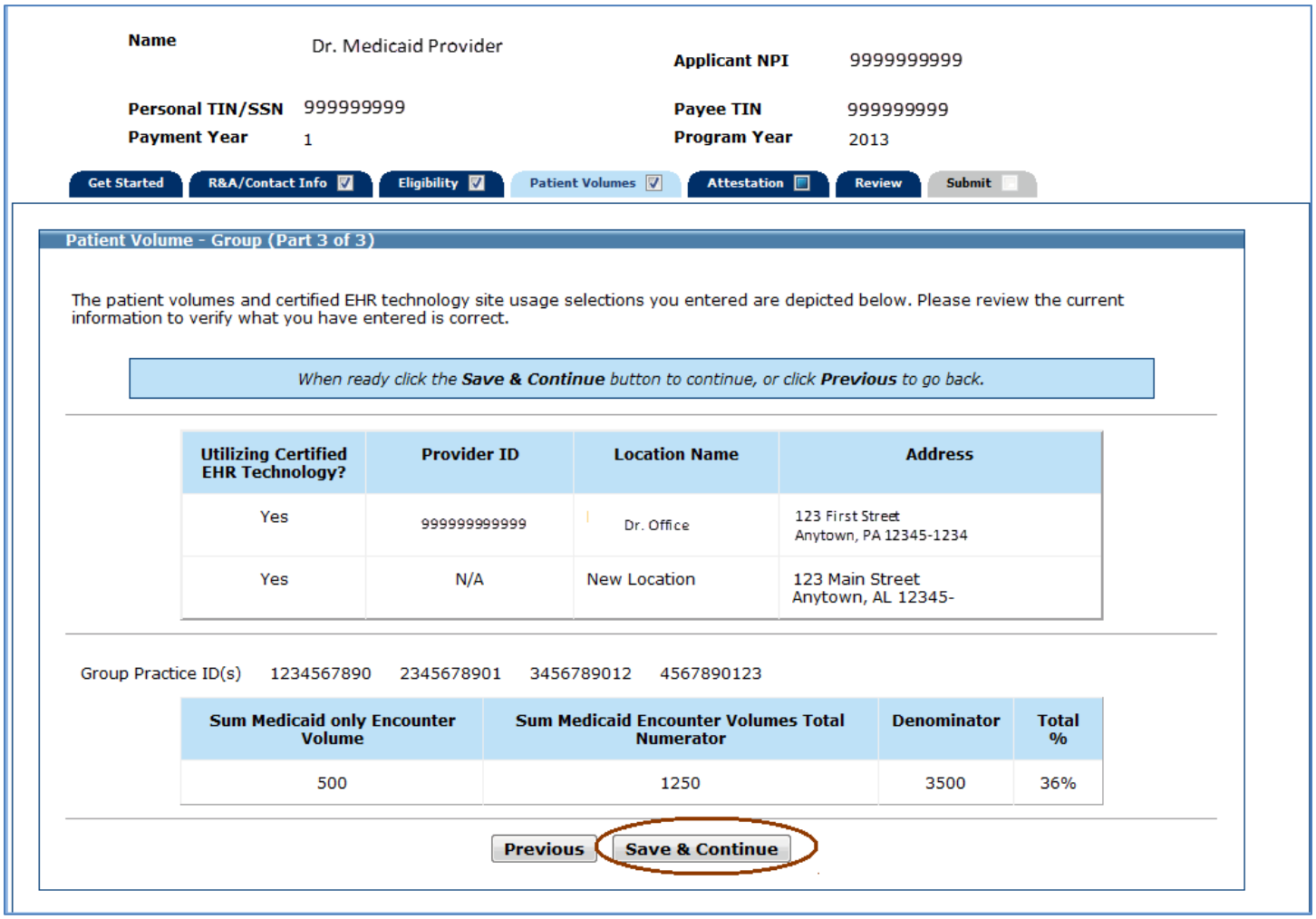

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - Group (Part 3 of 3)
Please indicate in the box(es) provided, the Group Practice Provider ID(s) you will use to report patient volume requirements. You must enter at least one Group Practice Provider ID.
* 1234567890
2345678901
3456789012
4567890123
Please check the box if more than 4 Group Practice Provider IDs will be used in reporting patient volumes
For reporting Group patient volumes:
1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2) There is an auditable data source to support the clinic's patient volume determination; and
3) So long as the practice and EP's decide to use one methodology in each year (in other words, clinics could not have some of the EP's using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EP's may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.
Please enter patient volumes where indicated. You must enter volumes in all fields below, if volumes do not apply, enter zero.
An Encounter is defined as any services that were rendered on any one day to an individual enrolled in an eligible Medicaid program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Medicaid only Encounter Volume (In State Numerator)
Medicaid Encounter Volumes (Total Numerator)
Total Encounter Volume (Denominator)
* 500
* 1250
* 3500
Previous
Reset
Save & Continue

After selecting **Save & Continue** this panel will be updated with the locations where you are utilizing certified EHR technology, patient volumes you entered, all values summarized, and the Medicaid patient volume percentage. Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement. Pediatricians who do not meet the 30% Medicaid patient volume but meet the 20% Medicaid patient volume, will not receive the full incentive payment amount.

Click **Save & Continue** to proceed, or click **Previous** to go back.

Proceed to page 64 of this guide to continue with the application.

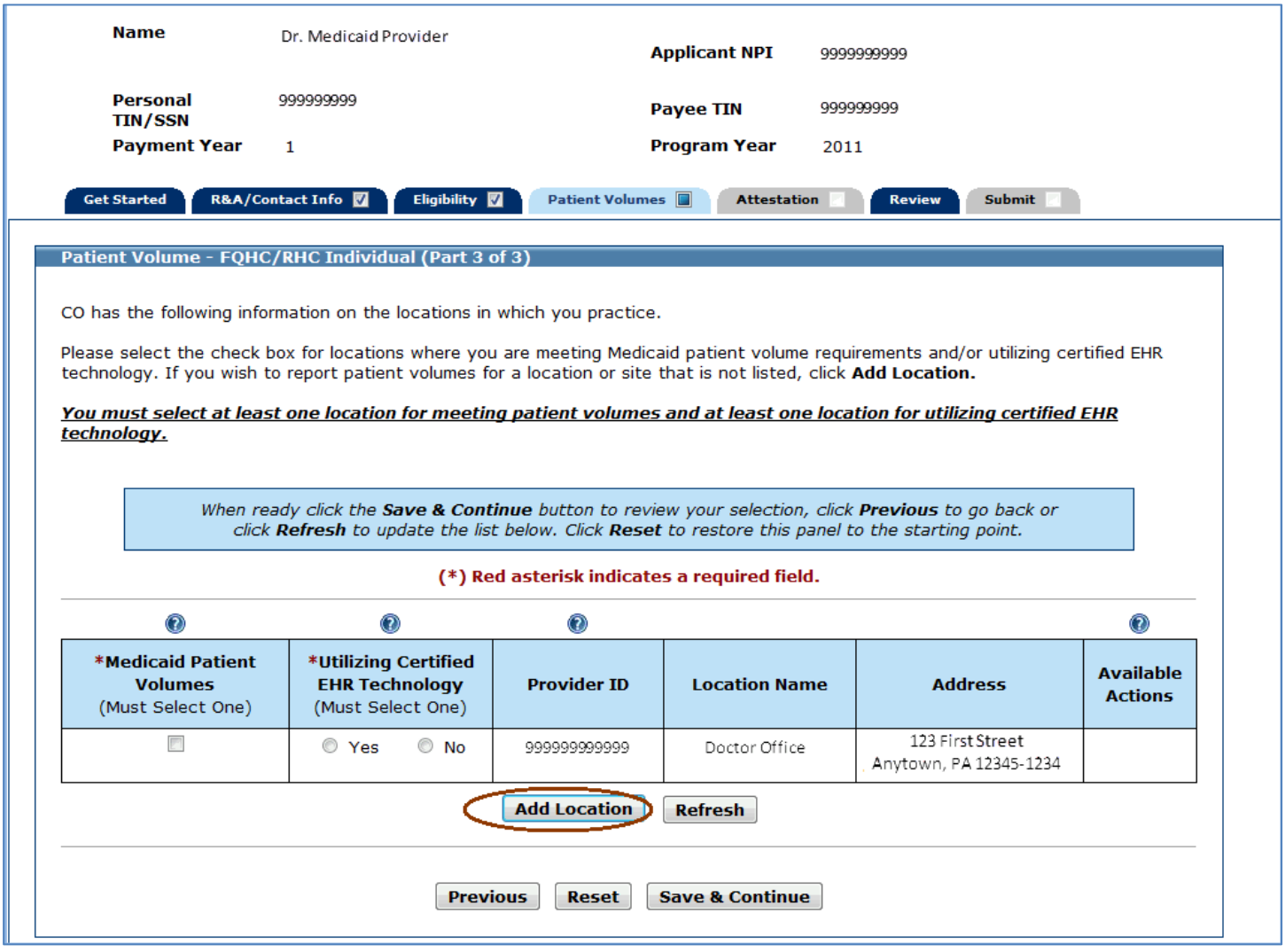


Patient Volume – FQHC/RHC Individual

The following pages will show you how to apply for the EHR Incentive program as an FQHC/RHC Individual provider. If you are not applying as an FQHC/RHC Individual provider, refer to the table on page 39 for more information.

Practice locations – MAPIR will present a list of locations that Connecticut Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information. If you do not have any locations to add, you can Click **Save & Continue** to continue to the next section.

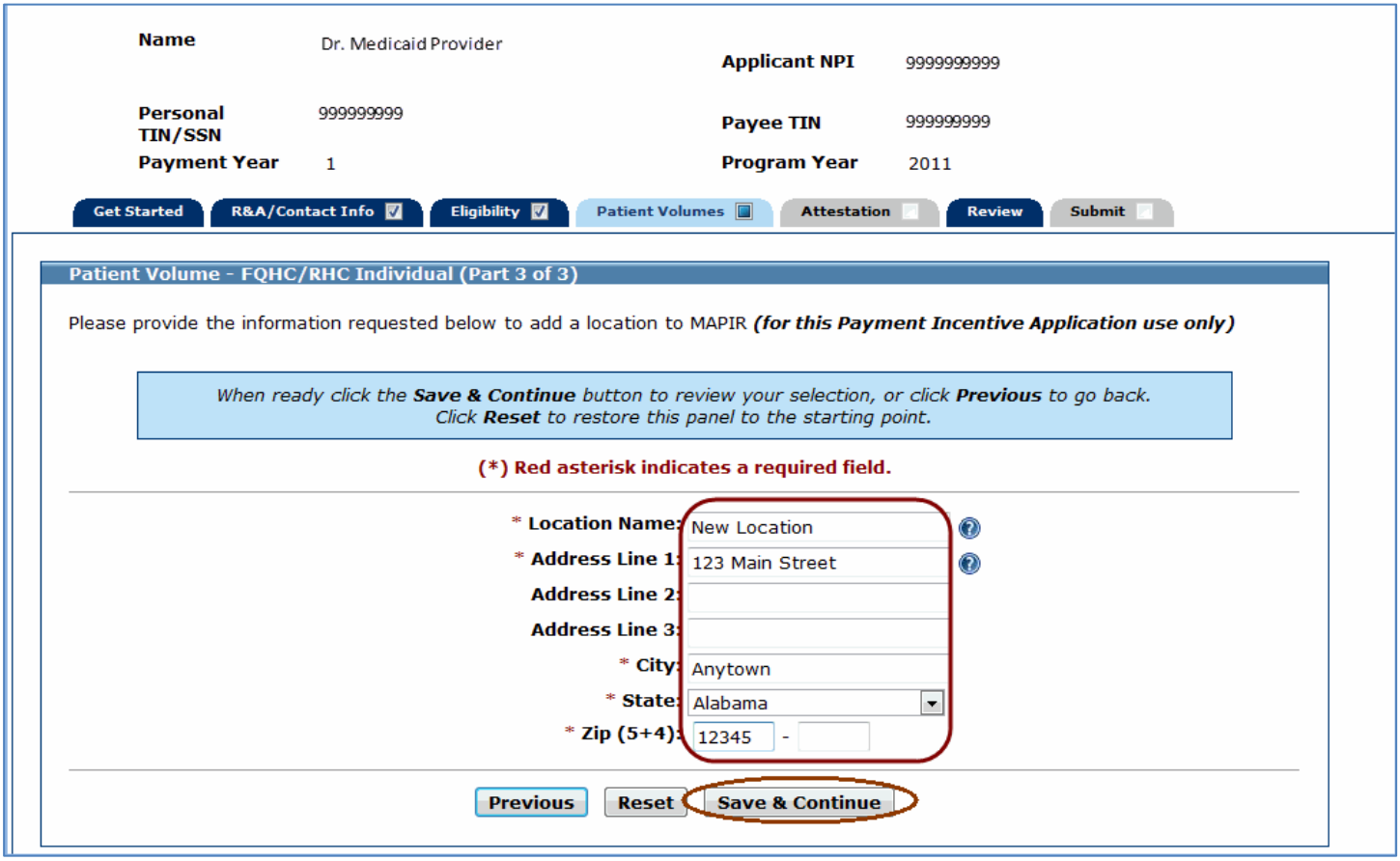
Review the listed locations. Add new locations by clicking **Add Location**.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - FQHC/RHC Individual (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Medicaid Patient Volumes (Must Select One)
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street
Anytown, PA 12345-1234
Add Location
Refresh
Previous
Reset
Save & Continue

If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested practice location information.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



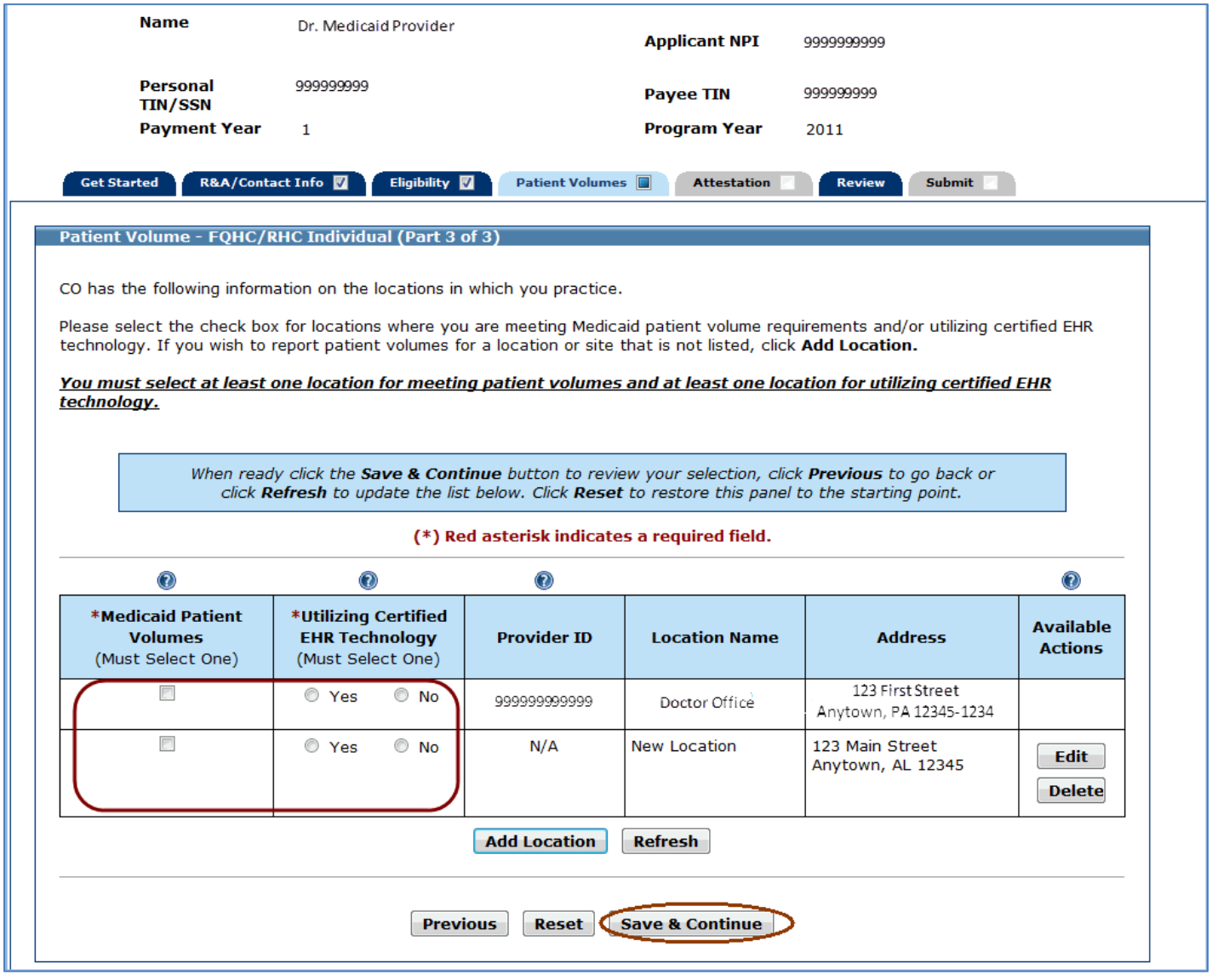
For each location, check whether you will report **Medicaid Patient Volumes** and whether you plan to **Utilize Certified EHR Technology**. You must select at least one location for meeting patient requirements and at least one location for utilizing certified EHR technology.

*Note: For every location listed on this screen, even if you did not select it as a location to meet patient requirements (**Medicaid Patient Volume** column), you must indicate if you are using certified EHR technology at this location by selecting Yes or No in the **Utilizing Certified EHR Technology** column.*

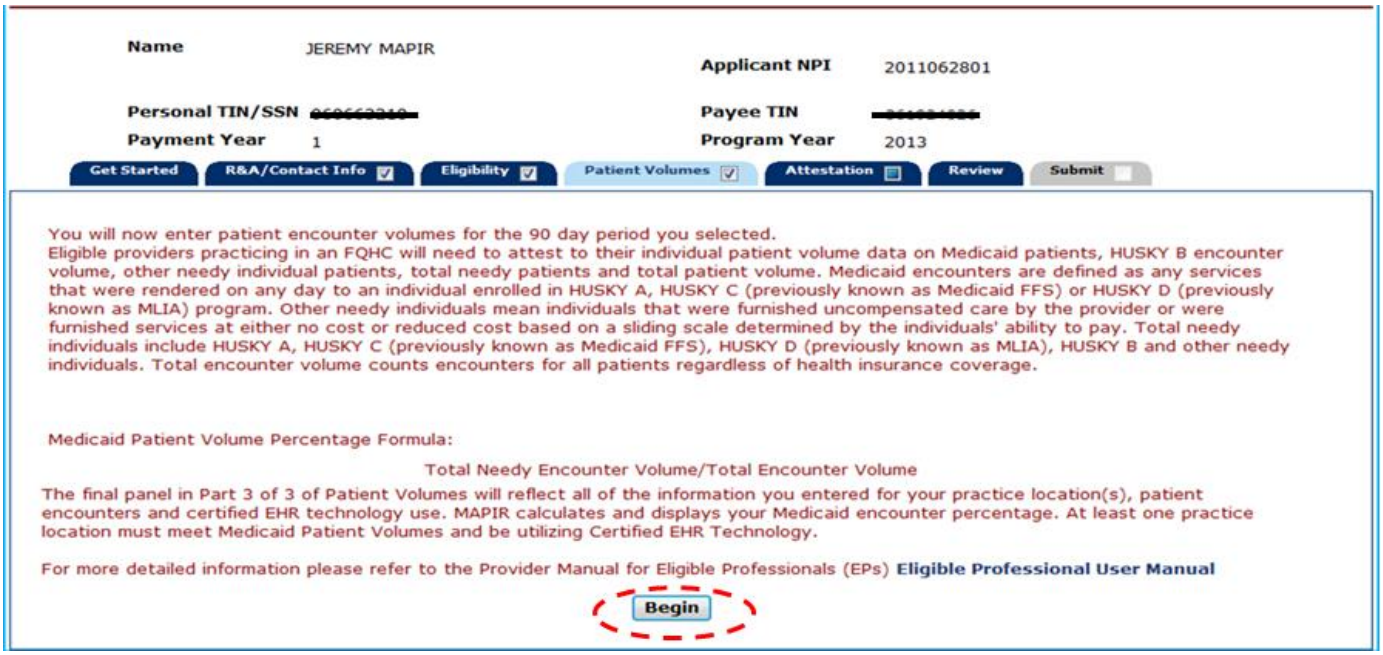
Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - FQHC/RHC Individual (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for meeting patient volumes and at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Medicaid Patient Volumes (Must Select One)
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street
Anytown, PA 12345-1234
Yes
No
N/A
New Location
123 Main Street
Anytown, AL 12345
Edit
Delete
Add Location
Refresh
Previous
Reset
Save & Continue

This screen gives details about the encounter data that would qualify towards patient volume. Click **Begin** to proceed to the screens where you will enter patient volumes.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
You will now enter patient encounter volumes for the 90 day period you selected.
Eligible providers practicing in an FQHC will need to attest to their individual patient volume data on Medicaid patients, HUSKY B encounter volume, other needy individual patients, total needy patients and total patient volume. Medicaid encounters are defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program. Other needy individuals mean individuals that were furnished uncompensated care by the provider or were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay. Total needy individuals include HUSKY A, HUSKY C (previously known as Medicaid FFS), HUSKY D (previously known as MLIA), HUSKY B and other needy individuals. Total encounter volume counts encounters for all patients regardless of health insurance coverage.
Medicaid Patient Volume Percentage Formula:
Total Needy Encounter Volume/Total Encounter Volume
The final panel in Part 3 of 3 of Patient Volumes will reflect all of the information you entered for your practice location(s), patient encounters and certified EHR technology use. MAPIR calculates and displays your Medicaid encounter percentage. At least one practice location must meet Medicaid Patient Volumes and be utilizing Certified EHR Technology.
For more detailed information please refer to the Provider Manual for Eligible Professionals (EPs) Eligible Professional User Manual
Begin

The following formula is used to calculate the Patient Volume when the individual practitioner who practices predominantly in an FQHC submits his/her own patient volumes:

Medicaid Patient Volume Percentage Formula – FQHC/RHC Individual

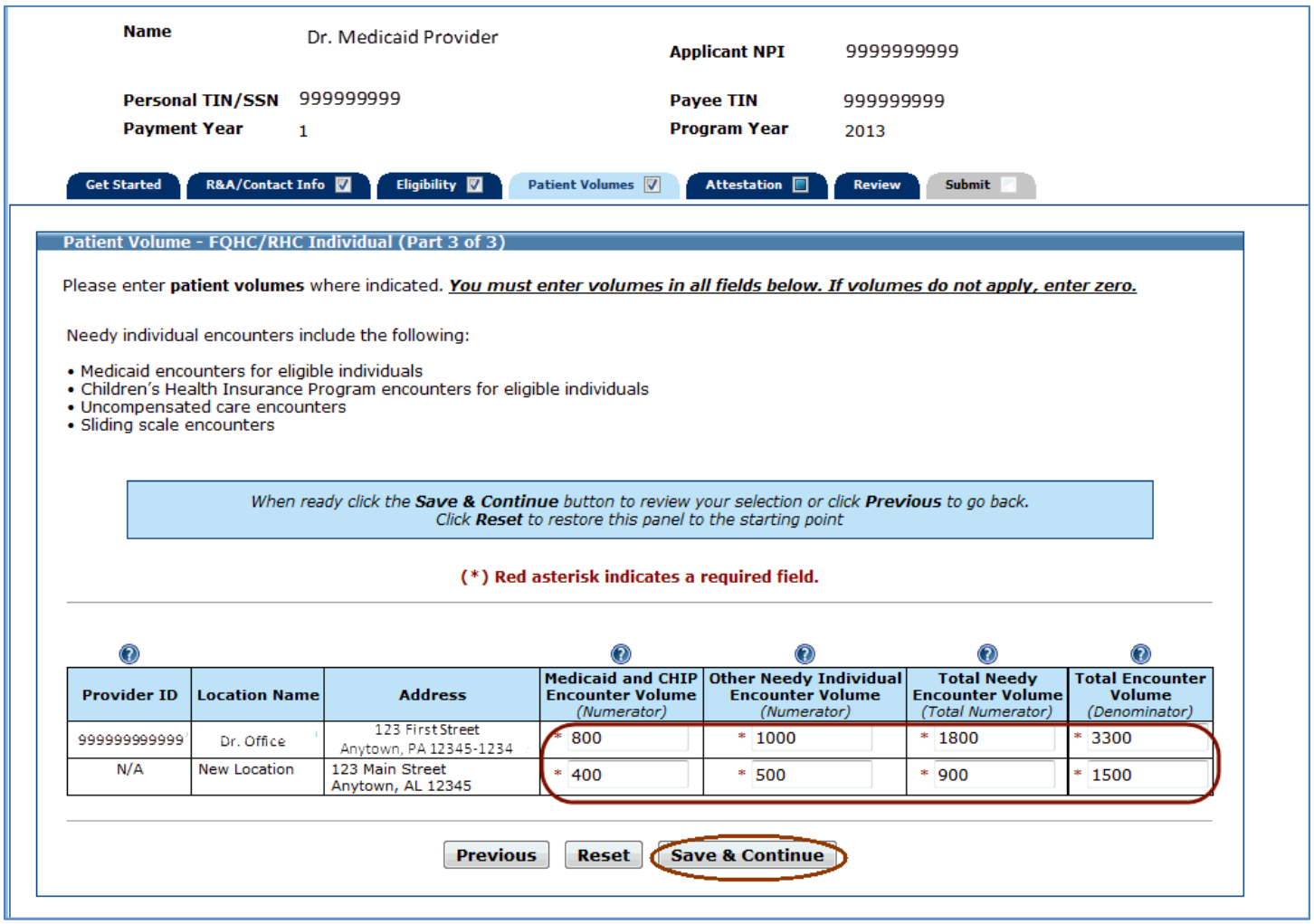
Total Needy Encounter Volume

Divided by

Total Encounter Volume

Enter patient volumes for each location listed. Medicaid encounter is defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program. For Connecticut, HUSKY B patients fall under the Children's Health Insurance Program (CHIP). Other needy individuals mean individuals that were furnished uncompensated care by the provider or were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay. Total needy individuals include HUSKY A, HUSKY C, HUSKY D, HUSKY B and other needy individuals.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



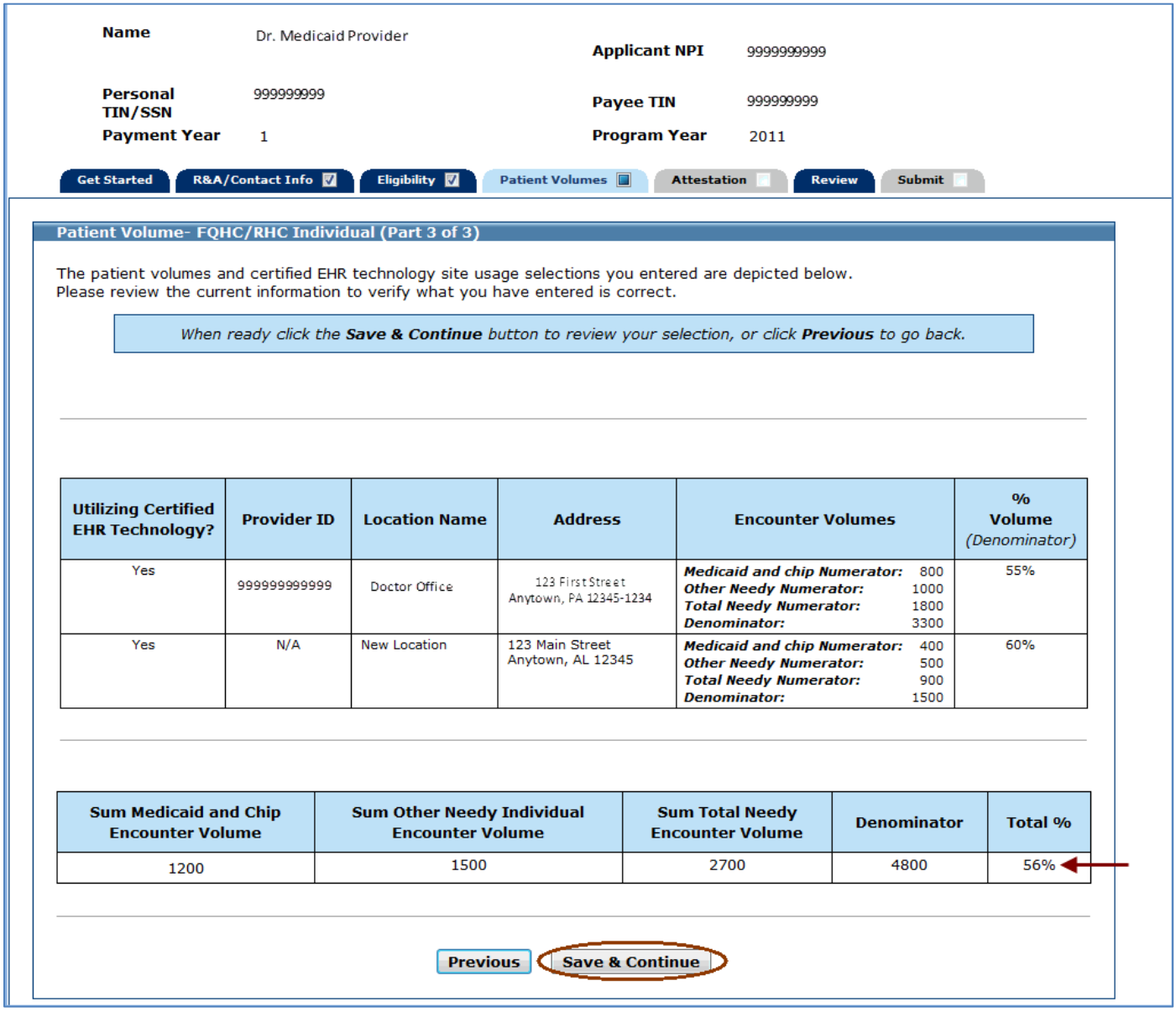
This screen displays the locations you are utilizing certified EHR technology, patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement. Pediatricians who do not meet the 30% Medicaid patient volume but meet the 20% Medicaid patient volume, will not receive the full incentive payment amount.

Click **Save & Continue** to proceed, or click **Previous** to go back.

Proceed to page 64 of this guide to continue with the application.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2011

Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Patient Volume- FQHC/RHC Individual (Part 3 of 3)

The patient volumes and certified EHR technology site usage selections you entered are depicted below.
Please review the current information to verify what you have entered is correct.

*When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back.*

Utilizing Certified EHR Technology?	Provider ID	Location Name	Address	Encounter Volumes	% Volume *(Denominator)*
Yes	999999999999	Doctor Office	123 First Street Anytown, PA 12345-1234	***Medicaid and chip Numerator:*** 800 ***Other Needy Numerator:*** 1000 ***Total Needy Numerator:*** 1800 ***Denominator:*** 3300	55%
Yes	N/A	New Location	123 Main Street Anytown, AL 12345	***Medicaid and chip Numerator:*** 400 ***Other Needy Numerator:*** 500 ***Total Needy Numerator:*** 900 ***Denominator:*** 1500	60%

Sum Medicaid and Chip Encounter Volume	Sum Other Needy Individual Encounter Volume	Sum Total Needy Encounter Volume	Denominator	Total %
1200	1500	2700	4800	56%

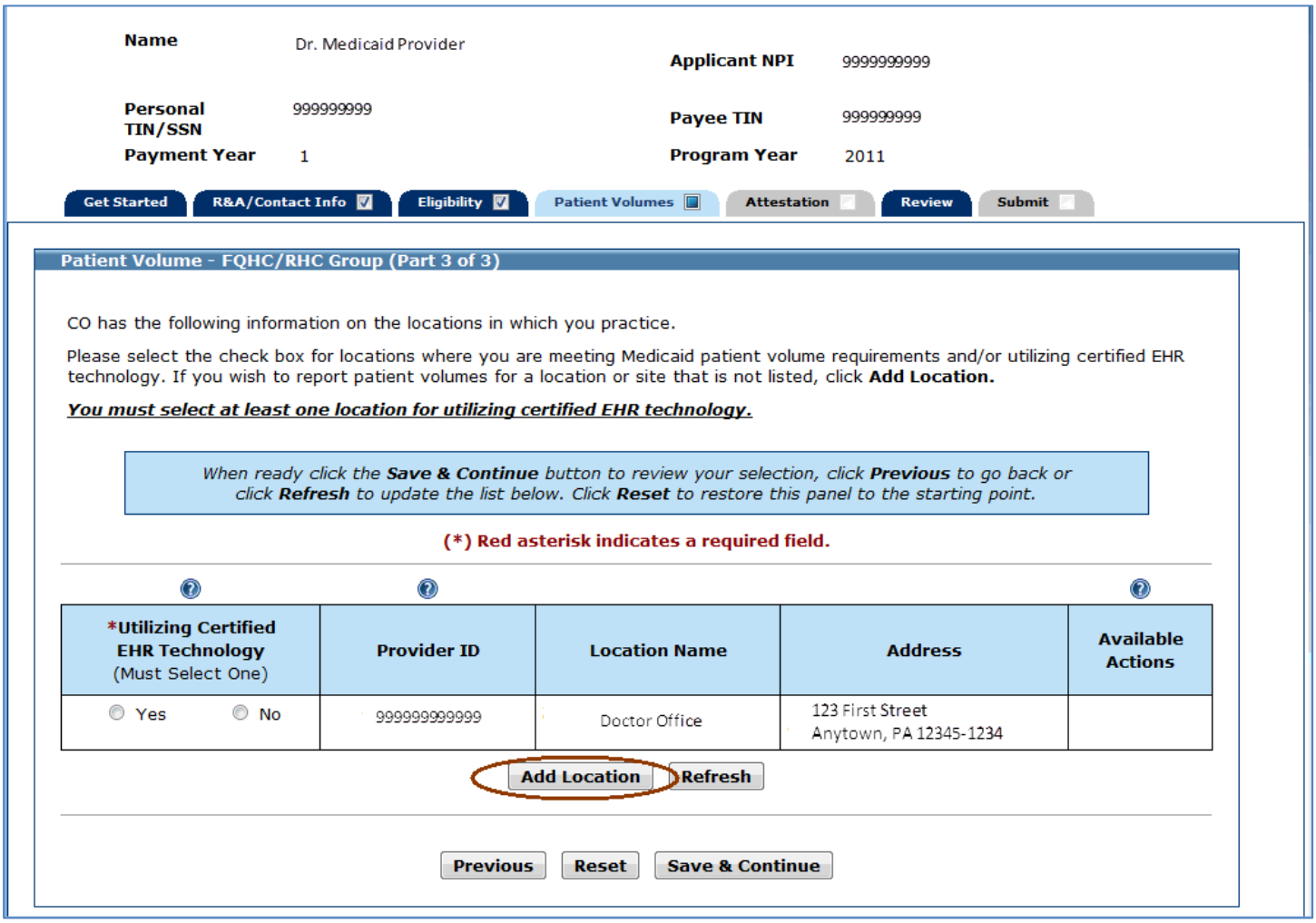
Previous | Save & Continue

Patient Volume – FQHC/RHC Group

The following pages will show you how to apply for the EHR Incentive program as an FQHC/RHC Group provider. If you are not applying as an FQHC/RHC Group provider, refer to the table on page 39 for more information.

Practice locations – MAPIR will present a list of locations that Connecticut Medicaid program office has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information. If you do not have any locations to add, you can Click **Save & Continue** to continue to the next section.

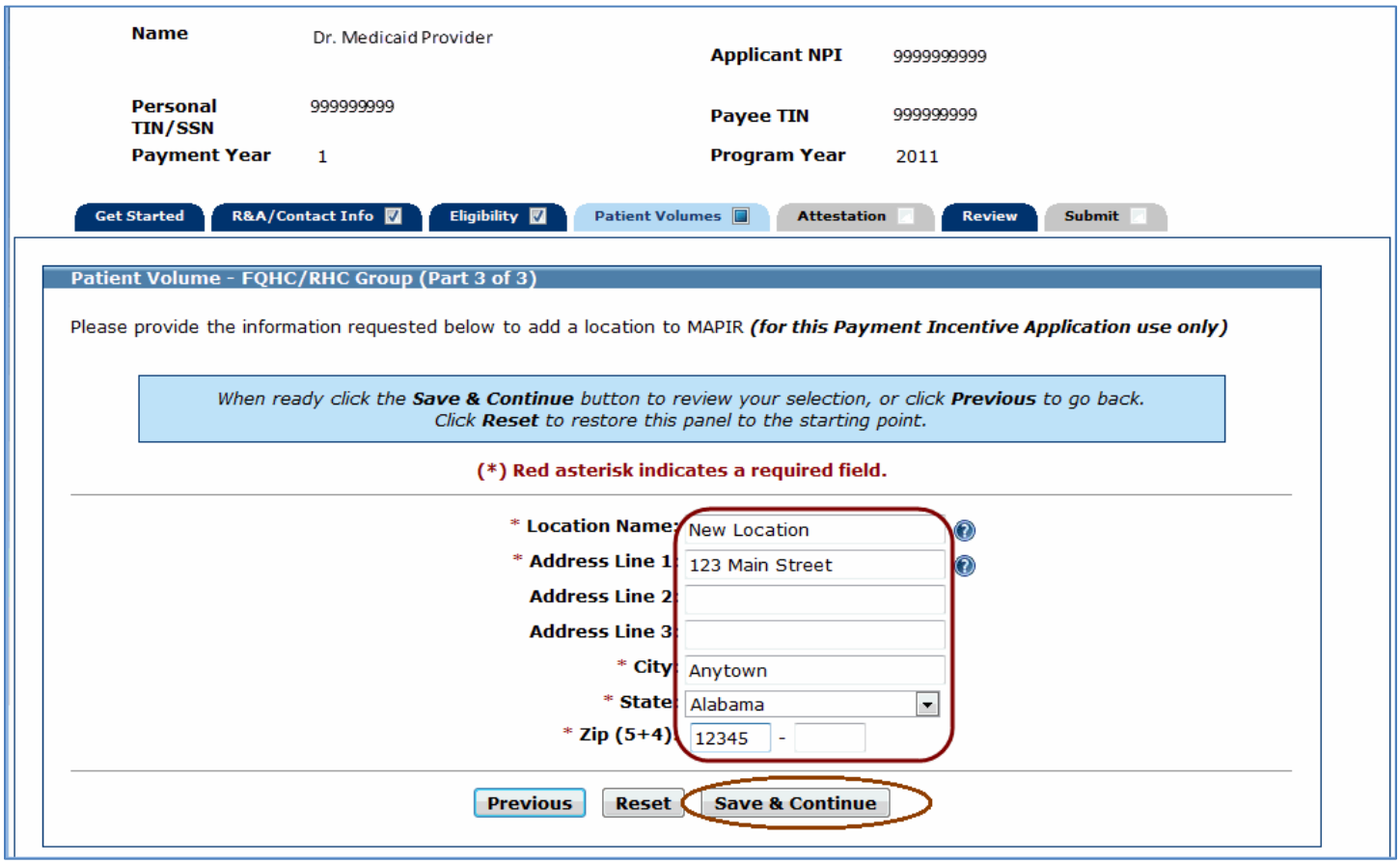
Review the listed locations. Add new locations by clicking **Add Location**.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - FQHC/RHC Group (Part 3 of 3)
CO has the following information on the locations in which you practice.
Please select the check box for locations where you are meeting Medicaid patient volume requirements and/or utilizing certified EHR technology. If you wish to report patient volumes for a location or site that is not listed, click Add Location.
You must select at least one location for utilizing certified EHR technology.
When ready click the Save & Continue button to review your selection, click Previous to go back or click Refresh to update the list below. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*Utilizing Certified EHR Technology (Must Select One)
Provider ID
Location Name
Address
Available Actions
Yes
No
999999999999
Doctor Office
123 First Street
Anytown, PA 12345-1234
Add Location
Refresh
Previous
Reset
Save & Continue

If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested practice location information.

Click **Save & Continue** to proceed, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



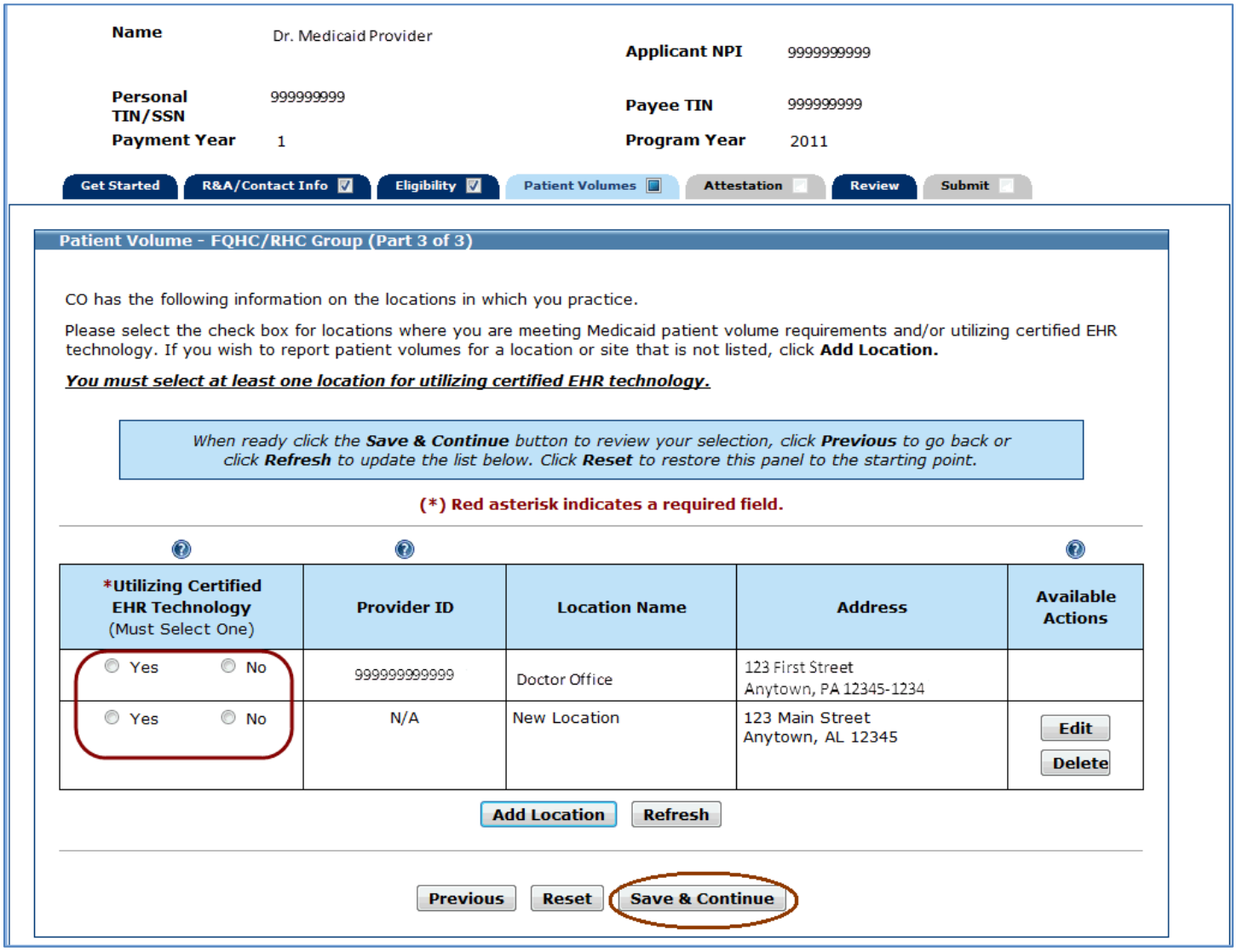
For each location, check whether you plan to utilize certified EHR technology. You must select at least one location for utilizing certified EHR technology.

*Note: You must indicate if you are using certified EHR technology at every location listed on this screen by selecting Yes or No in the **Utilizing Certified EHR Technology** column.*

Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

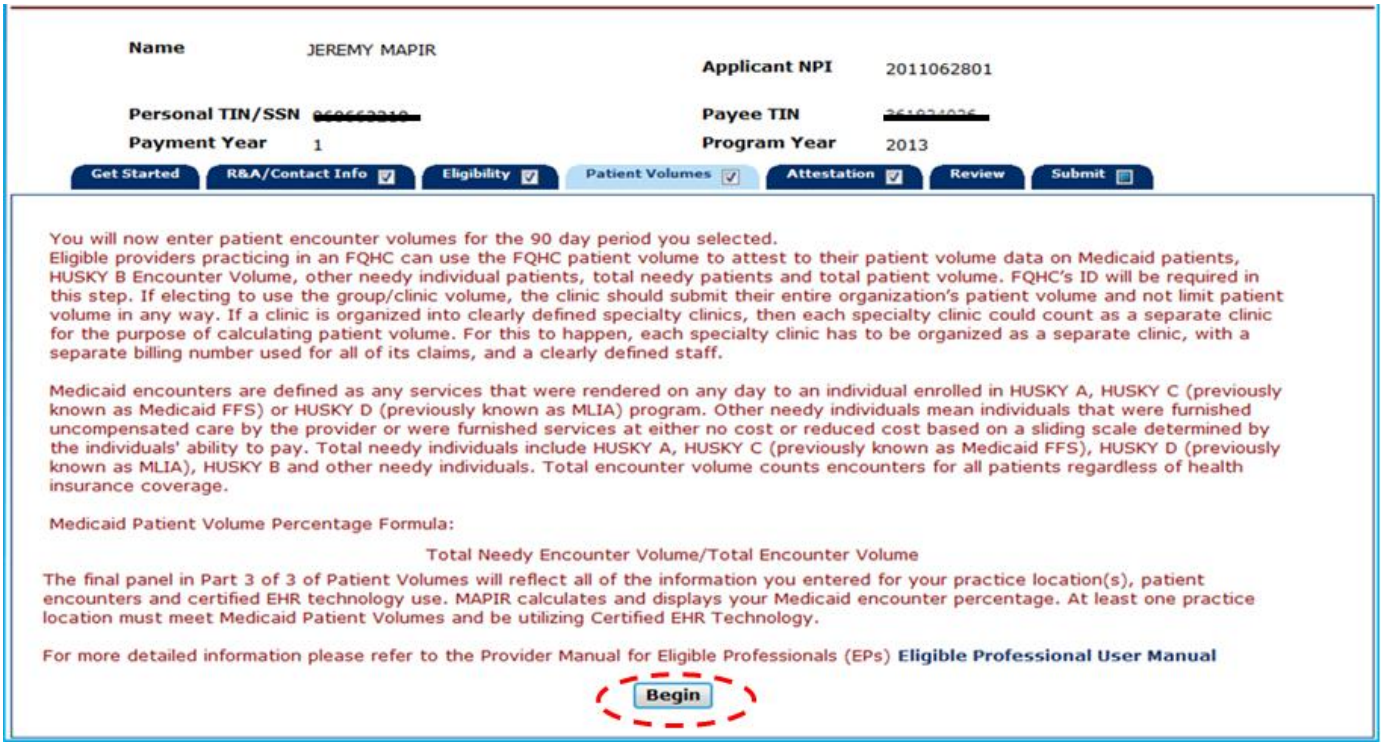
*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



This screen gives details about the definition of a group/clinic and the encounter data that would qualify towards patient volume. If electing to use the group/clinic volume, the group/clinic should submit their entire organization's patient volume and not limit patient volume in any way. If a group/clinic is organized into clearly defined specialty groups/clinics, then each specialty group/ clinic could count as a separate group/clinic for the purpose of calculating patient volume. For this to happen, each specialty group/clinic has to be organized as a separate group/clinic, with a separate billing number used for all of its claims, and a clearly defined staff.

Click **Begin** to proceed to the screens where you will enter patient volumes.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
You will now enter patient encounter volumes for the 90 day period you selected.
Eligible providers practicing in an FQHC can use the FQHC patient volume to attest to their patient volume data on Medicaid patients, HUSKY B Encounter Volume, other needy individual patients, total needy patients and total patient volume. FQHC's ID will be required in this step. If electing to use the group/clinic volume, the clinic should submit their entire organization's patient volume and not limit patient volume in any way. If a clinic is organized into clearly defined specialty clinics, then each specialty clinic could count as a separate clinic for the purpose of calculating patient volume. For this to happen, each specialty clinic has to be organized as a separate clinic, with a separate billing number used for all of its claims, and a clearly defined staff.
Medicaid encounters are defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program. Other needy individuals mean individuals that were furnished uncompensated care by the provider or were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay. Total needy individuals include HUSKY A, HUSKY C (previously known as Medicaid FFS), HUSKY D (previously known as MLIA), HUSKY B and other needy individuals. Total encounter volume counts encounters for all patients regardless of health insurance coverage.
Medicaid Patient Volume Percentage Formula:
Total Needy Encounter Volume/Total Encounter Volume
The final panel in Part 3 of 3 of Patient Volumes will reflect all of the information you entered for your practice location(s), patient encounters and certified EHR technology use. MAPIR calculates and displays your Medicaid encounter percentage. At least one practice location must meet Medicaid Patient Volumes and be utilizing Certified EHR Technology.
For more detailed information please refer to the Provider Manual for Eligible Professionals (EPs) Eligible Professional User Manual
Begin

The following formula is used to calculate the Patient Volume when the individual practitioner who practices predominantly in an FQHC submits patient volumes for the FQHC as a proxy for his/her own patient volume:

Medicaid Patient Volume Percentage Formula – FQHC/RHC Group

Total Needy Encounter Volume

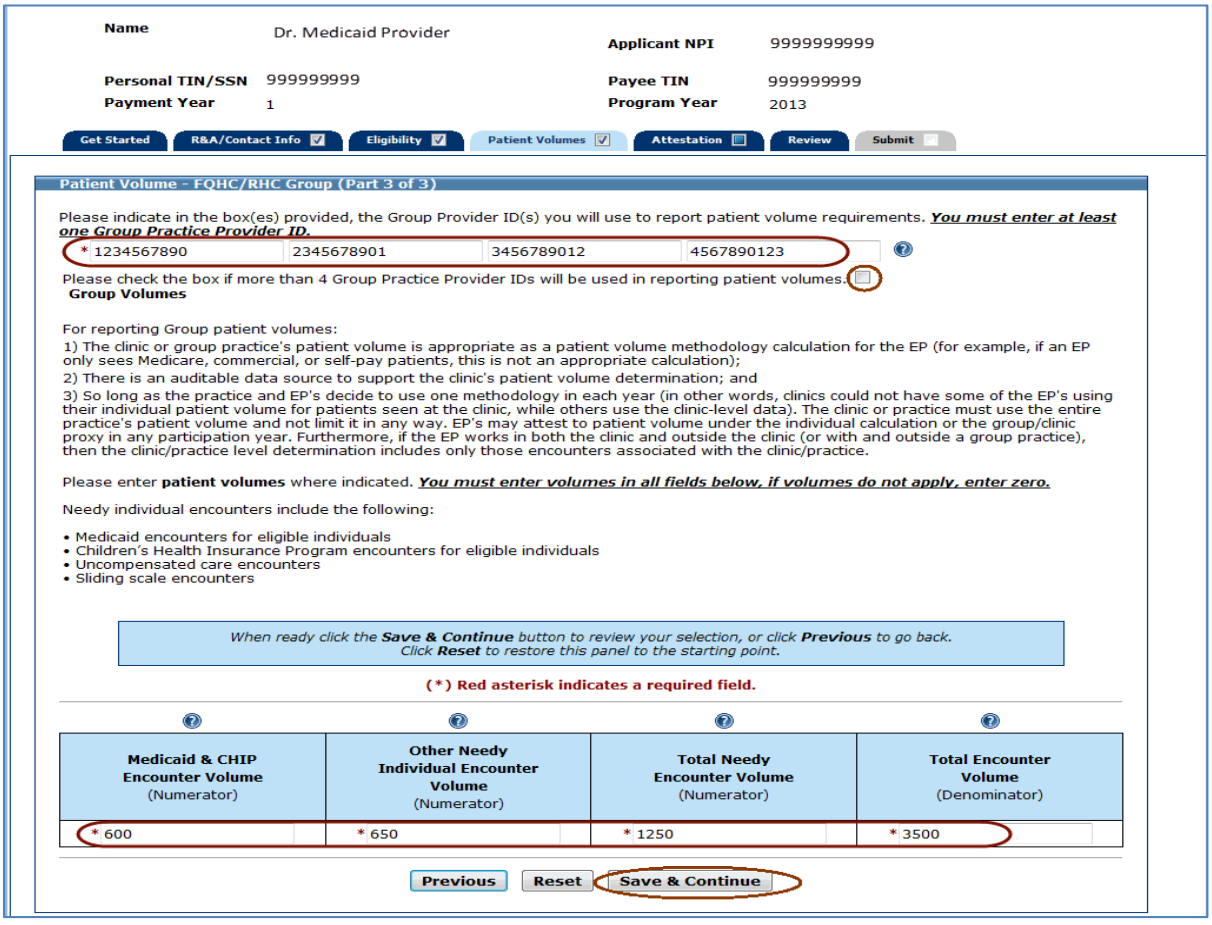
Divided by

Total Encounter Volume

Enter patient volumes for each location listed. Medicaid encounter is defined as any services that were rendered on any day to an individual enrolled in HUSKY A, HUSKY C (previously known as Medicaid FFS) or HUSKY D (previously known as MLIA) program. For Connecticut, HUSKY B patients fall under the Children's Health Insurance Program (CHIP). Other needy individuals mean individuals that were furnished uncompensated care by the provider or were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay. Total needy individuals include HUSKY A, HUSKY C, HUSKY D, HUSKY B and other needy individuals.

If you listed four **Group Practice Provider IDs** and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs. **You will be required to upload the documentation for all additional group NPI numbers and provider names in MAPIR.**

Enter **Patient Volumes.** Click **Save & Continue** to proceed, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

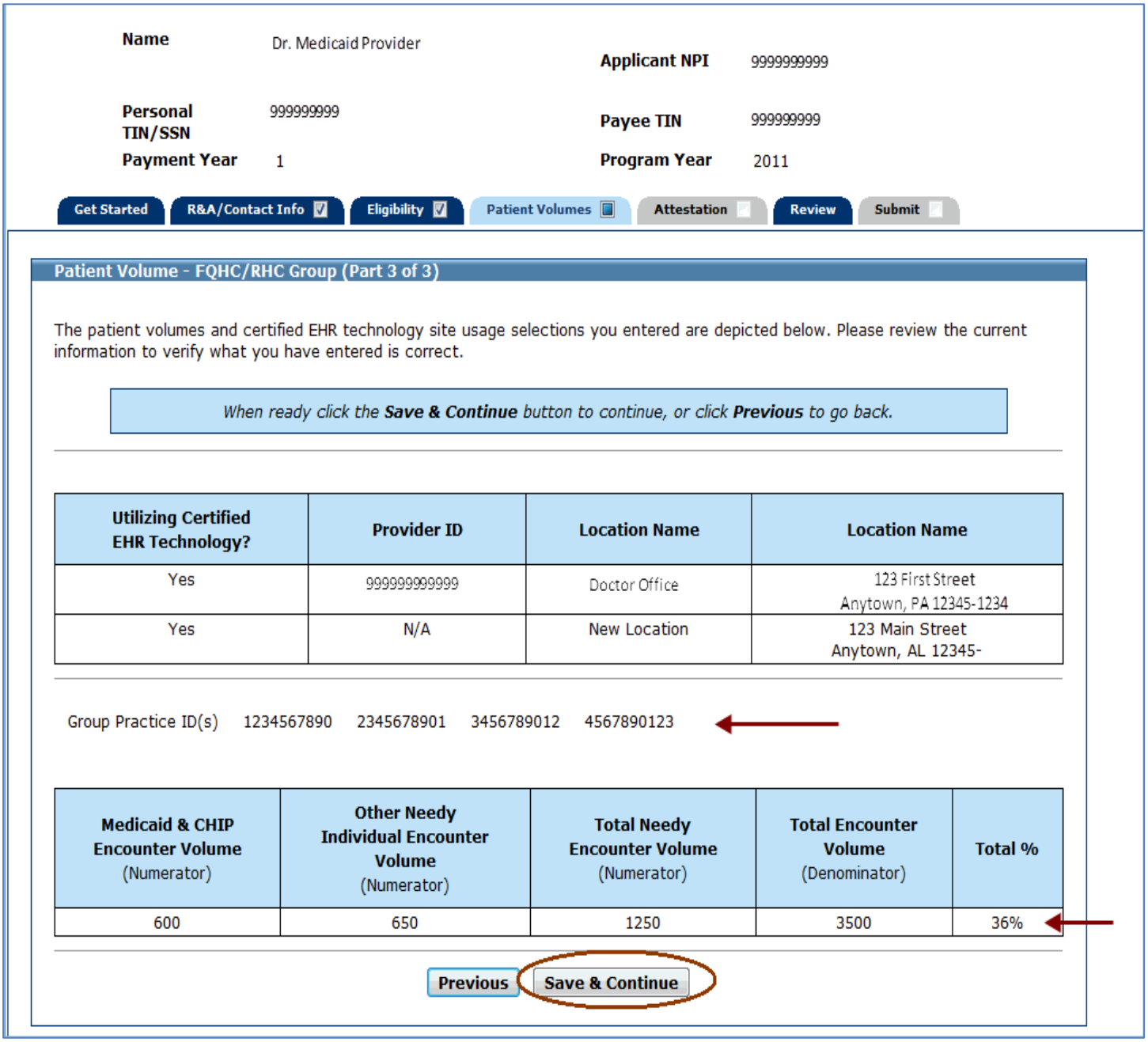

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volume - FQHC/RHC Group (Part 3 of 3)
Please indicate in the box(es) provided, the Group Provider ID(s) you will use to report patient volume requirements. You must enter at least one Group Practice Provider ID.
* 1234567890
2345678901
3456789012
4567890123
Please check the box if more than 4 Group Practice Provider IDs will be used in reporting patient volumes.
Group Volumes
For reporting Group patient volumes:
1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2) There is an auditable data source to support the clinic's patient volume determination; and
3) So long as the practice and EP's decide to use one methodology in each year (in other words, clinics could not have some of the EP's using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EP's may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.
Please enter patient volumes where indicated. You must enter volumes in all fields below, if volumes do not apply, enter zero.
Needy individual encounters include the following:
• Medicaid encounters for eligible individuals
• Children's Health Insurance Program encounters for eligible individuals
• Uncompensated care encounters
• Sliding scale encounters
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Medicaid & CHIP Encounter Volume (Numerator)
Other Needy Individual Encounter Volume (Numerator)
Total Needy Encounter Volume (Numerator)
Total Encounter Volume (Denominator)
* 600
* 650
* 1250
* 3500
Previous
Reset
Save & Continue

This screen displays the locations where you are utilizing EHR technology, patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

Review the information for accuracy.

Note the **Total %** patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement. Pediatricians who do not meet the 30% Medicaid patient volume but meet the 20% Medicaid patient volume, will not receive the full incentive payment amount.

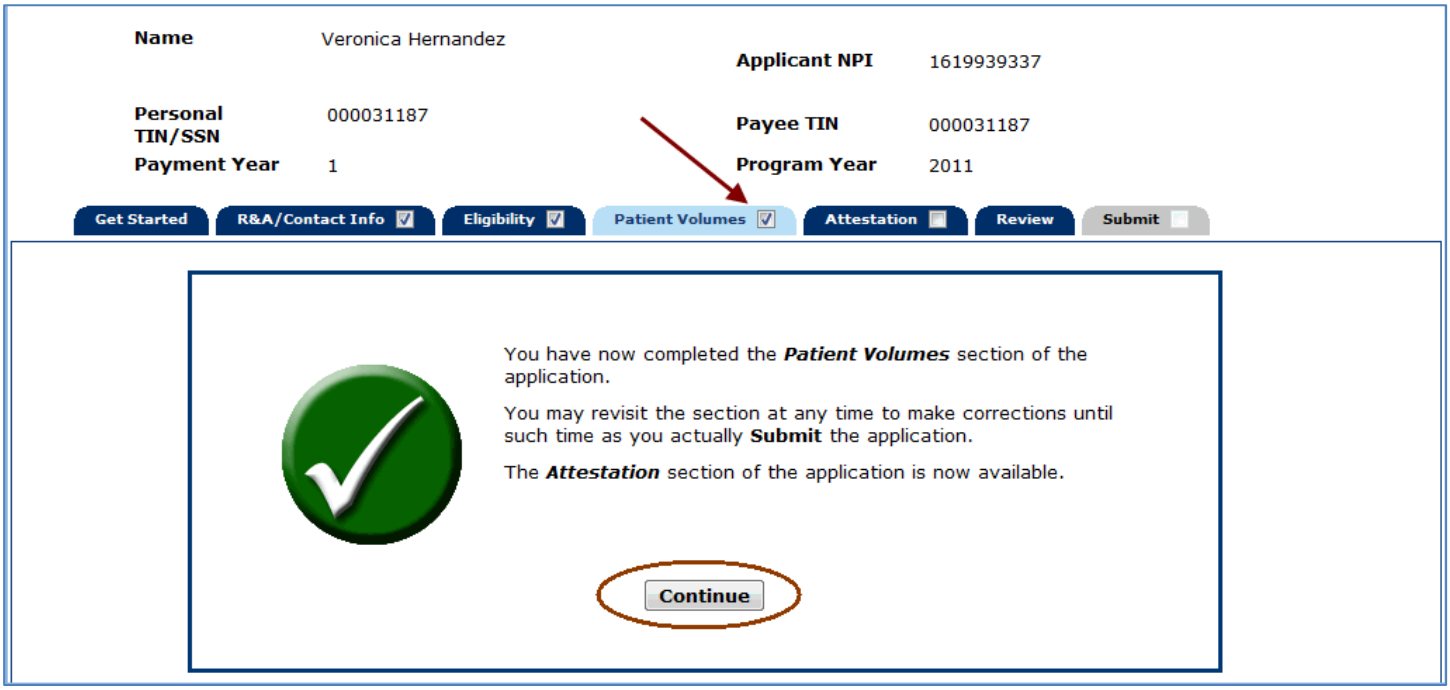
Click **Save & Continue** to proceed, or click **Previous** to go back.



This screen confirms you successfully completed the **Patient Volume** section.

Note the check box in the Patient Volume tab.

Click **Continue** to proceed to the **Attestation** section.



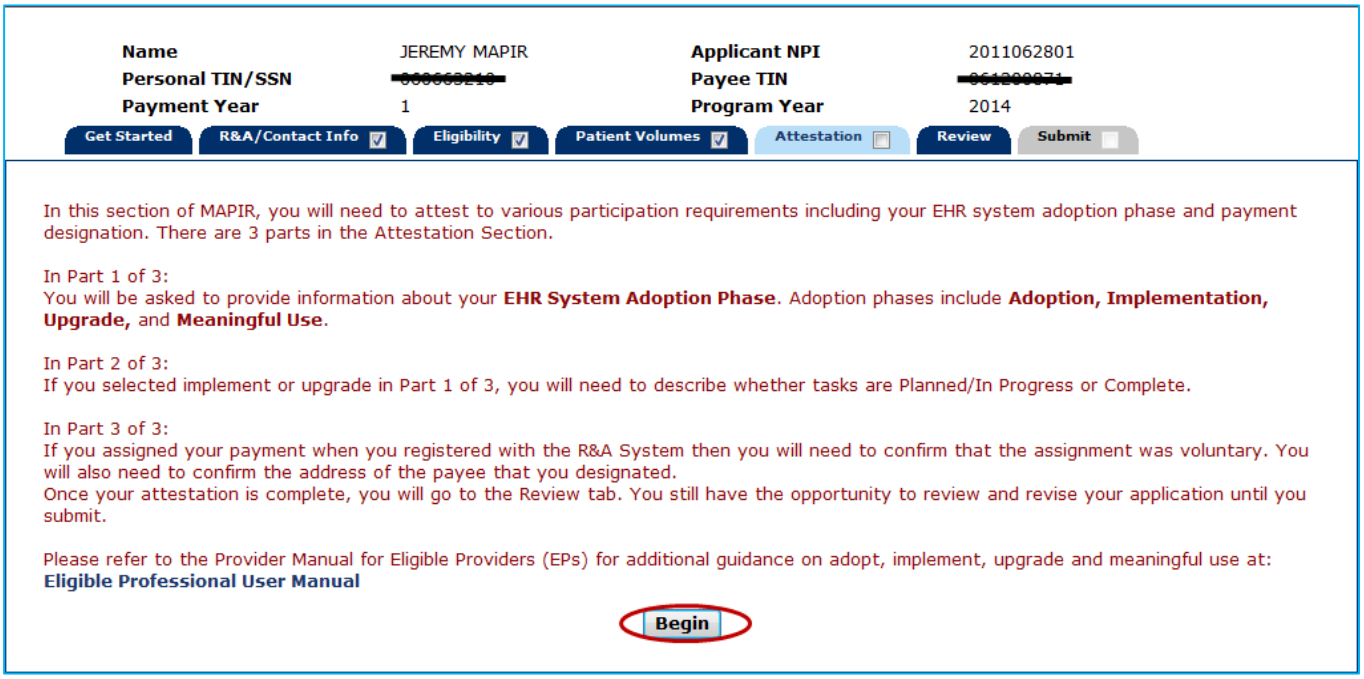
Step 5 – Attestation

This section will ask you to provide information about your **EHR System Adoption Phase**. Adoption phases include **Adoption**, **Implementation**, **Upgrade**, and **Meaningful Use**. Based on the adoption phase you select, you may be asked to complete additional information about activities related to that phase.

For the first year of participation in the Medicaid EHR Incentive program, Eligible Professionals will have the option to attest to **Adoption**, **Implementation**, **Upgrade,** or **Meaningful Use**. After the first year of participation, the Eligible Professionals are required to attest to **Meaningful Use**.

This initial Attestation screen provides information about this section.

Click **Begin** to continue to the **Attestation** section.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
In this section of MAPIR, you will need to attest to various participation requirements including your EHR system adoption phase and payment designation. There are 3 parts in the Attestation Section.
In Part 1 of 3:
You will be asked to provide information about your EHR System Adoption Phase. Adoption phases include Adoption, Implementation, Upgrade, and Meaningful Use.
In Part 2 of 3:
If you selected implement or upgrade in Part 1 of 3, you will need to describe whether tasks are Planned/In Progress or Complete.
In Part 3 of 3:
If you assigned your payment when you registered with the R&A System then you will need to confirm that the assignment was voluntary. You will also need to confirm the address of the payee that you designated.
Once your attestation is complete, you will go to the Review tab. You still have the opportunity to review and revise your application until you submit.
Please refer to the Provider Manual for Eligible Providers (EPs) for additional guidance on adopt, implement, upgrade and meaningful use at:
Eligible Professional User Manual
Begin

Attestation Phase (Part 1 of 3)

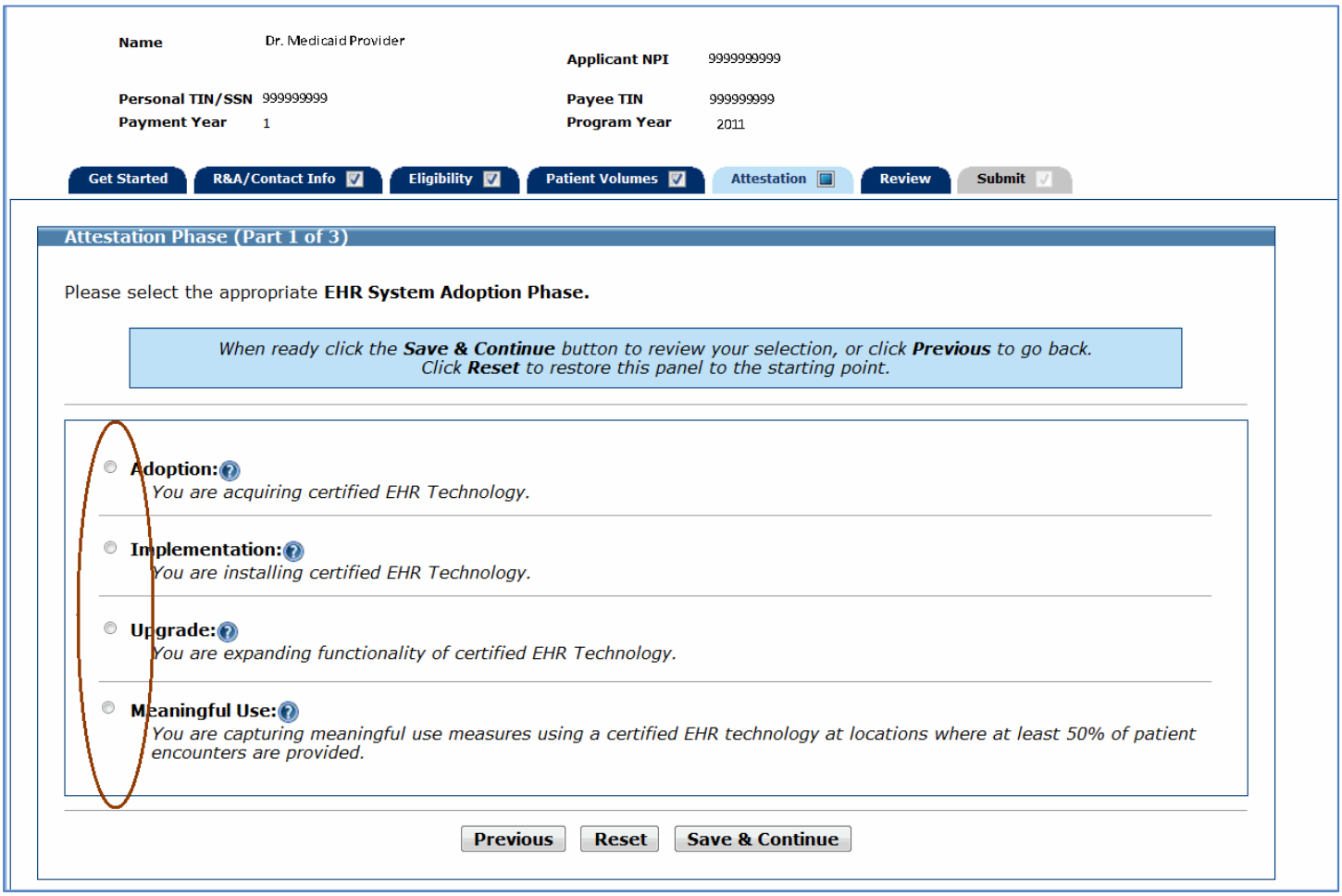
The Attestation Phase (Part 1 of 3) screen asks for the **EHR System Adoption Phase**.

The screen shown below is the Attestation Phase (Part 1 of 3) screen you will see if it is your first year participating (Payment Year 1).

If it is not your first year participating (Payment Year 2 or beyond), turn to page 77 of this guide.

After making your selection, the next screen you see will depend on the phase you selected.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



For **Adoption** continue to the next page of this guide.

For **Implementation** turn to page 68 of this guide.

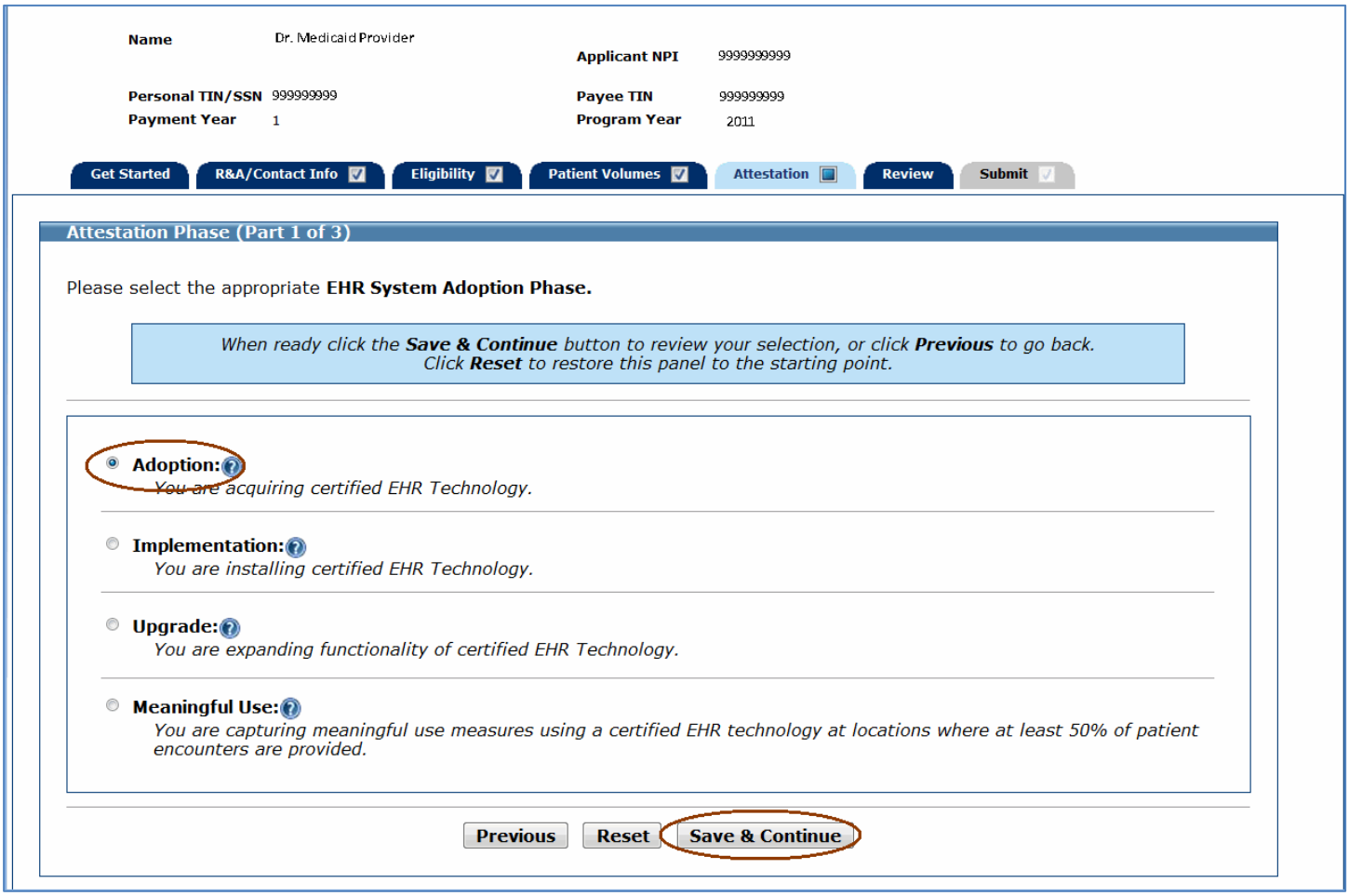
For **Upgrade** turn to page 72 of this guide.

For **Meaningful Use** turn to page 76 of this guide.

Adoption Phase

For **Adoption**, select the Adoption button. Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

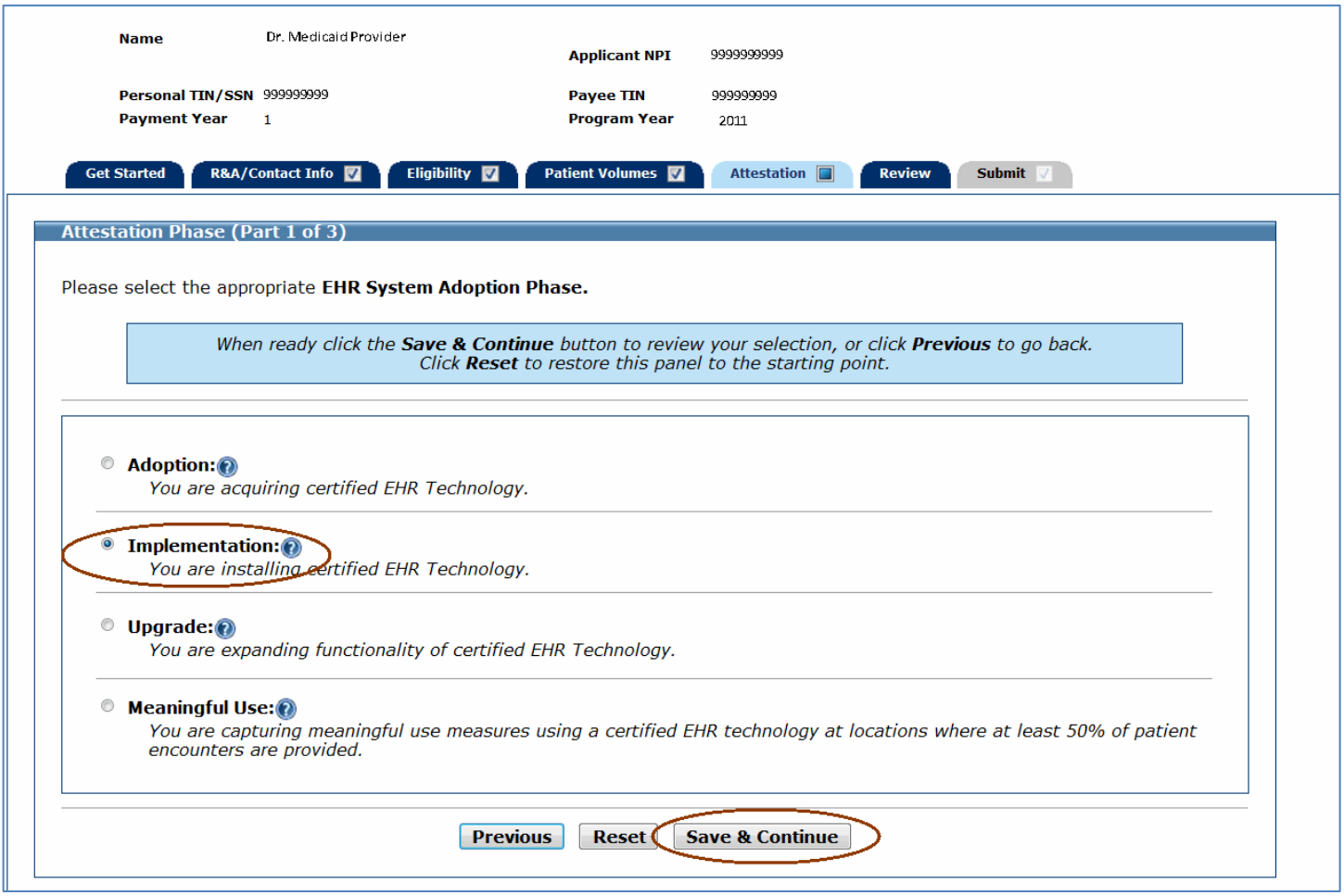
Proceed to page 171 of this guide.



Implementation Phase

For **Implementation** select the Implementation button.

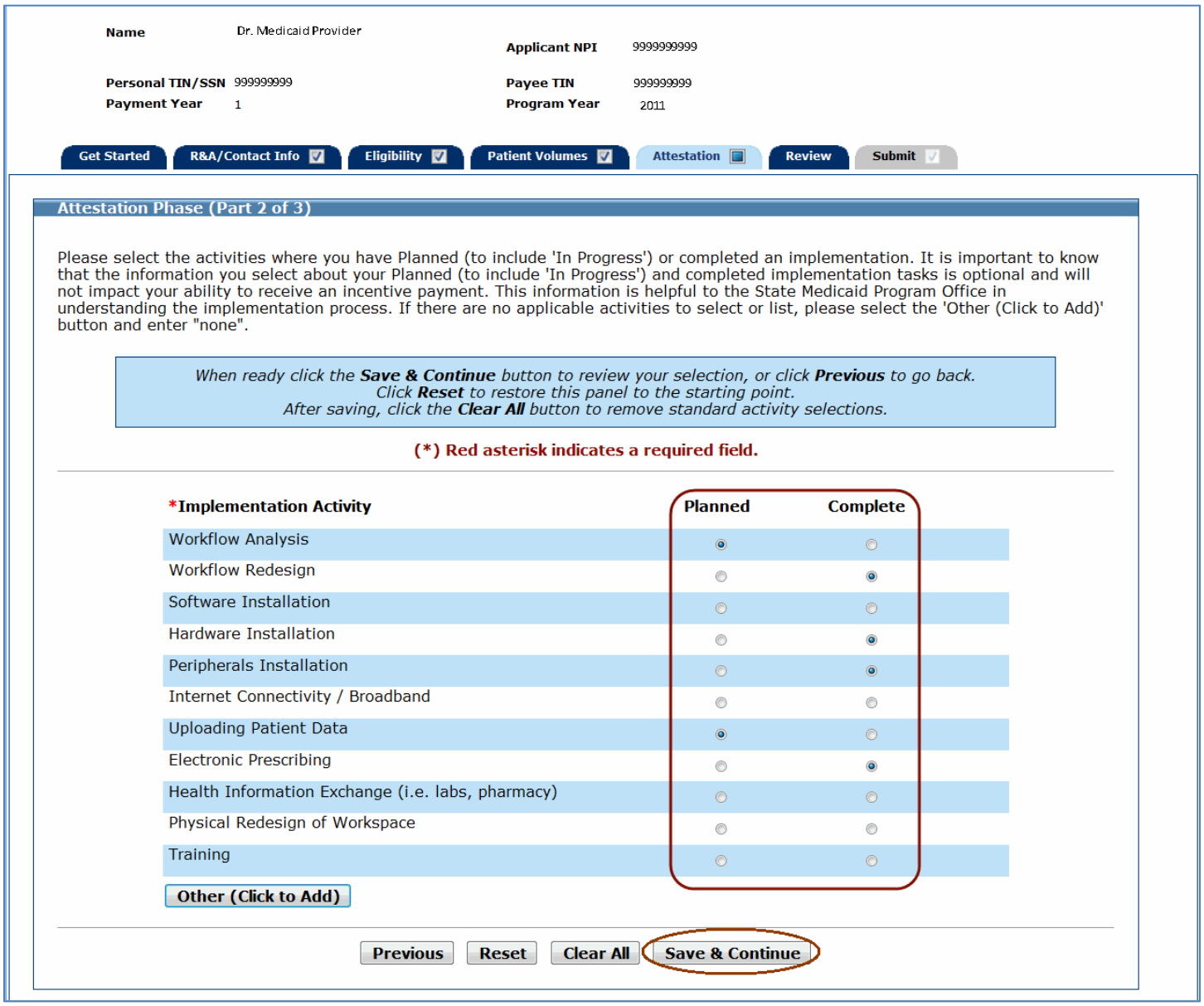
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



Select your **Implementation Activity** by selecting the **Planned** or **Complete** button**.**

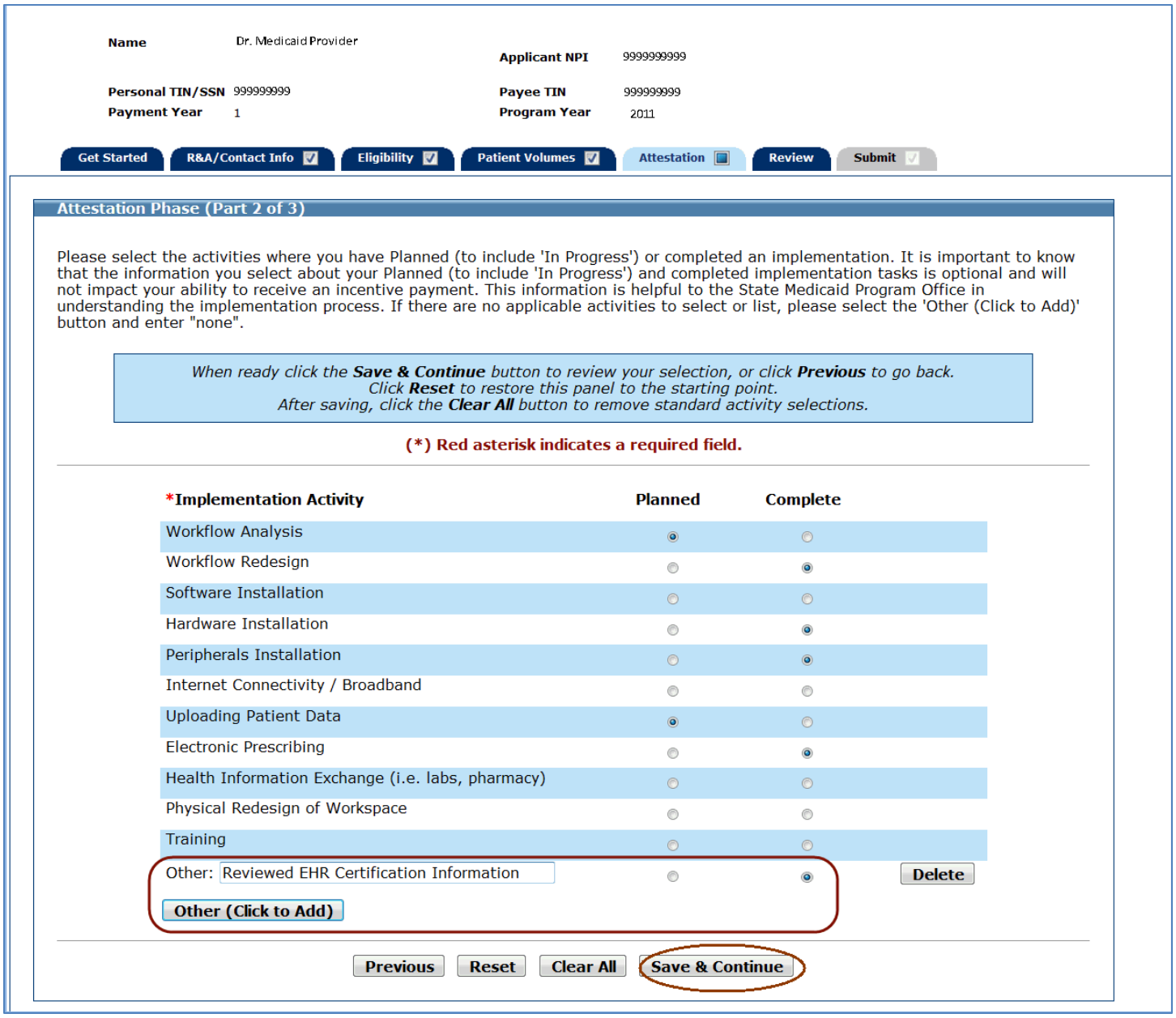
Click **Other** to add any additional **Implementation Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data. This is an example of a completed screen.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 2 of 3)
Please select the activities where you have Planned (to include 'In Progress') or completed an implementation. It is important to know that the information you select about your Planned (to include 'In Progress') and completed implementation tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the implementation process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
After saving, click the Clear All button to remove standard activity selections.
(*) Red asterisk indicates a required field.
*Implementation Activity
Planned
Complete
Workflow Analysis
Workflow Redesign
Software Installation
Hardware Installation
Peripherals Installation
Internet Connectivity / Broadband
Uploading Patient Data
Electronic Prescribing
Health Information Exchange (i.e. labs, pharmacy)
Physical Redesign of Workspace
Training
Other (Click to Add)
Previous
Reset
Clear All
Save & Continue

This screen shows an example of entering activities other than what was in the Implementation Activity listing.

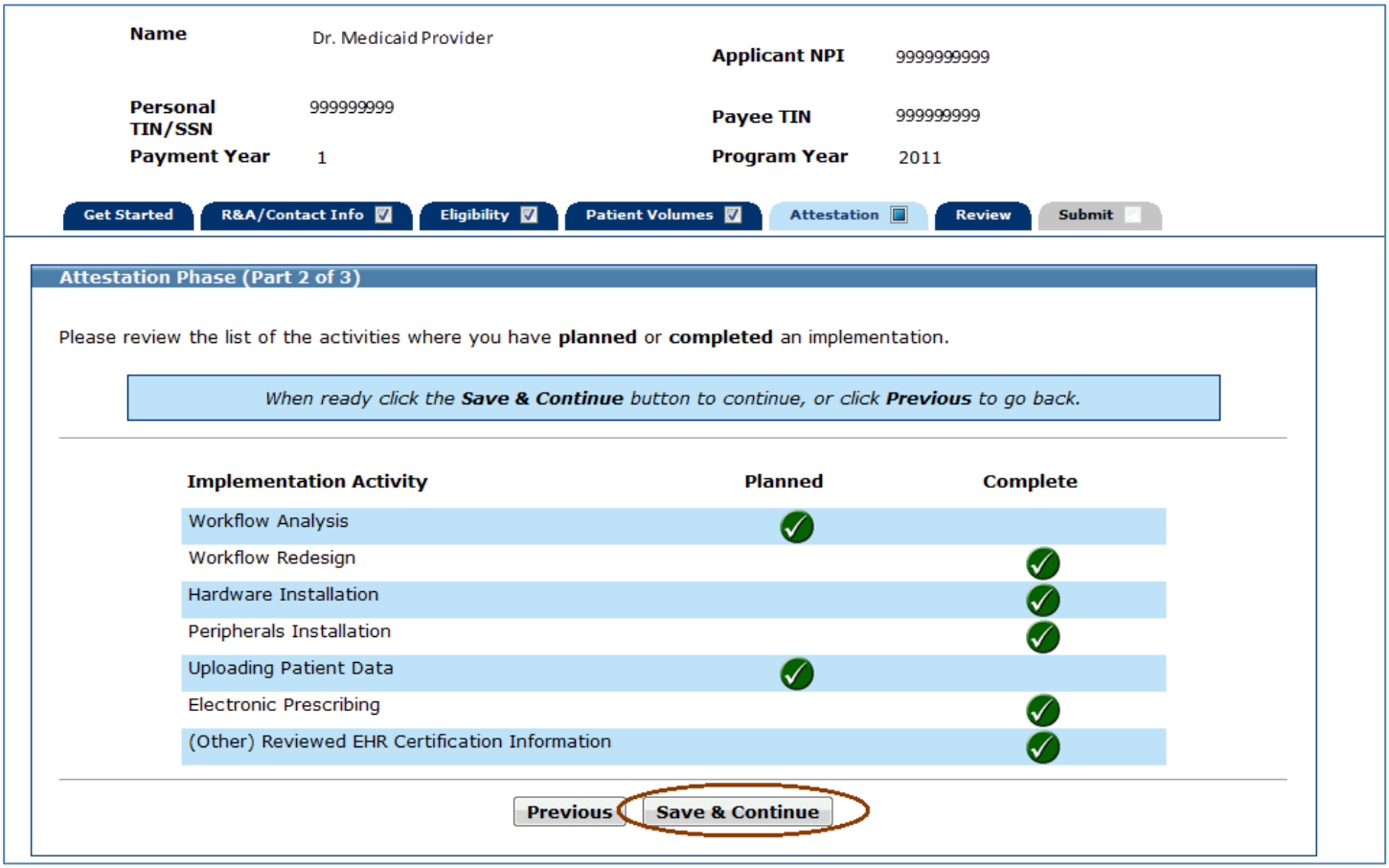
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 2 of 3)
Please select the activities where you have Planned (to include 'In Progress') or completed an implementation. It is important to know that the information you select about your Planned (to include 'In Progress') and completed implementation tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the implementation process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
After saving, click the Clear All button to remove standard activity selections.
(*) Red asterisk indicates a required field.
*Implementation Activity
Planned
Complete
Workflow Analysis
Workflow Redesign
Software Installation
Hardware Installation
Peripherals Installation
Internet Connectivity / Broadband
Uploading Patient Data
Electronic Prescribing
Health Information Exchange (i.e. labs, pharmacy)
Physical Redesign of Workspace
Training
Other: Reviewed EHR Certification Information
Delete
Other (Click to Add)
Previous
Reset
Clear All
Save & Continue

Review the **Implementation Activity** you selected.

Click **Save & Continue** to continue, or click **Previous** to go back.

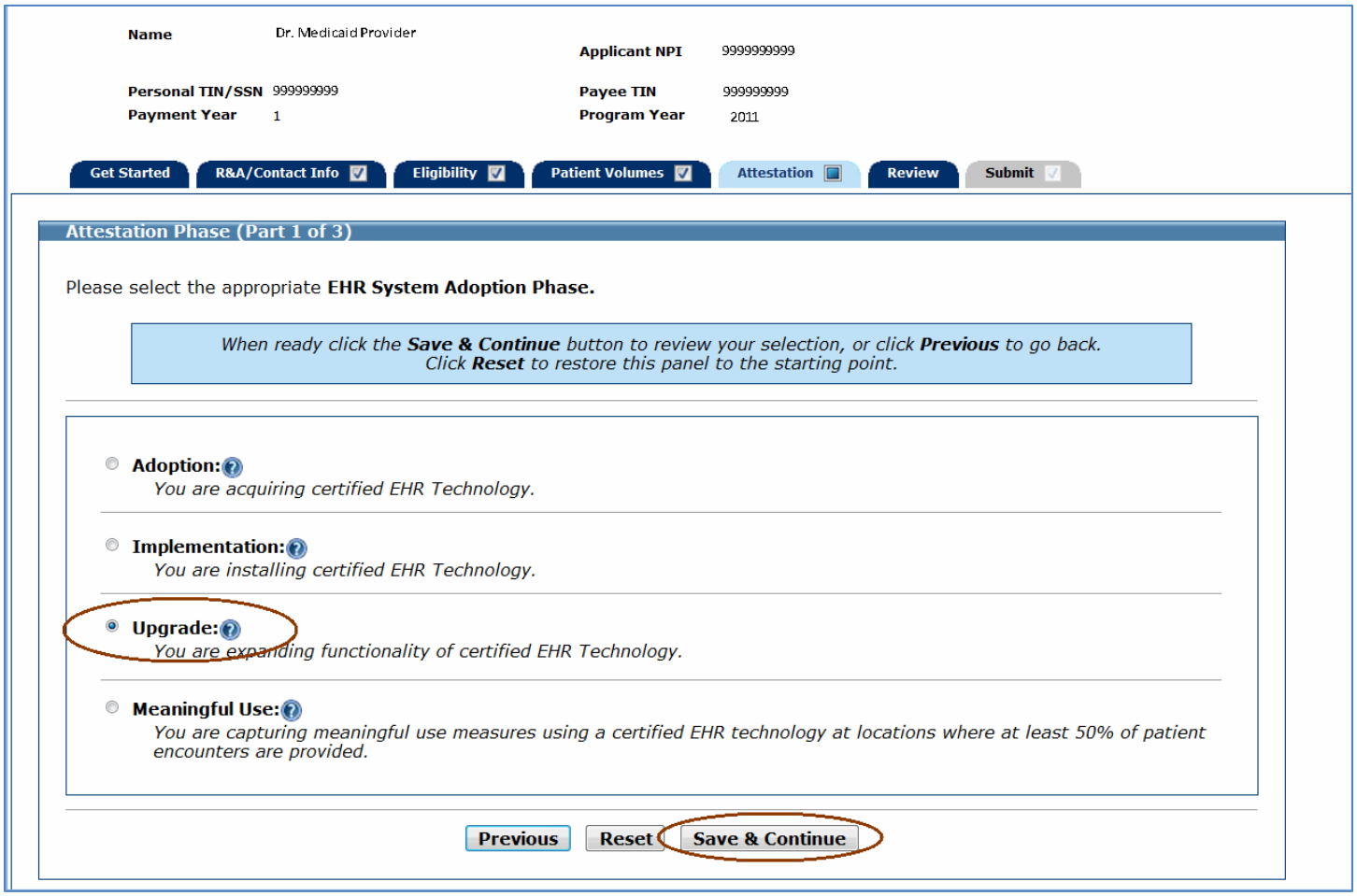
Proceed to page 171 in this guide to continue.



Upgrade Phase

For **Upgrade** select the Upgrade button.

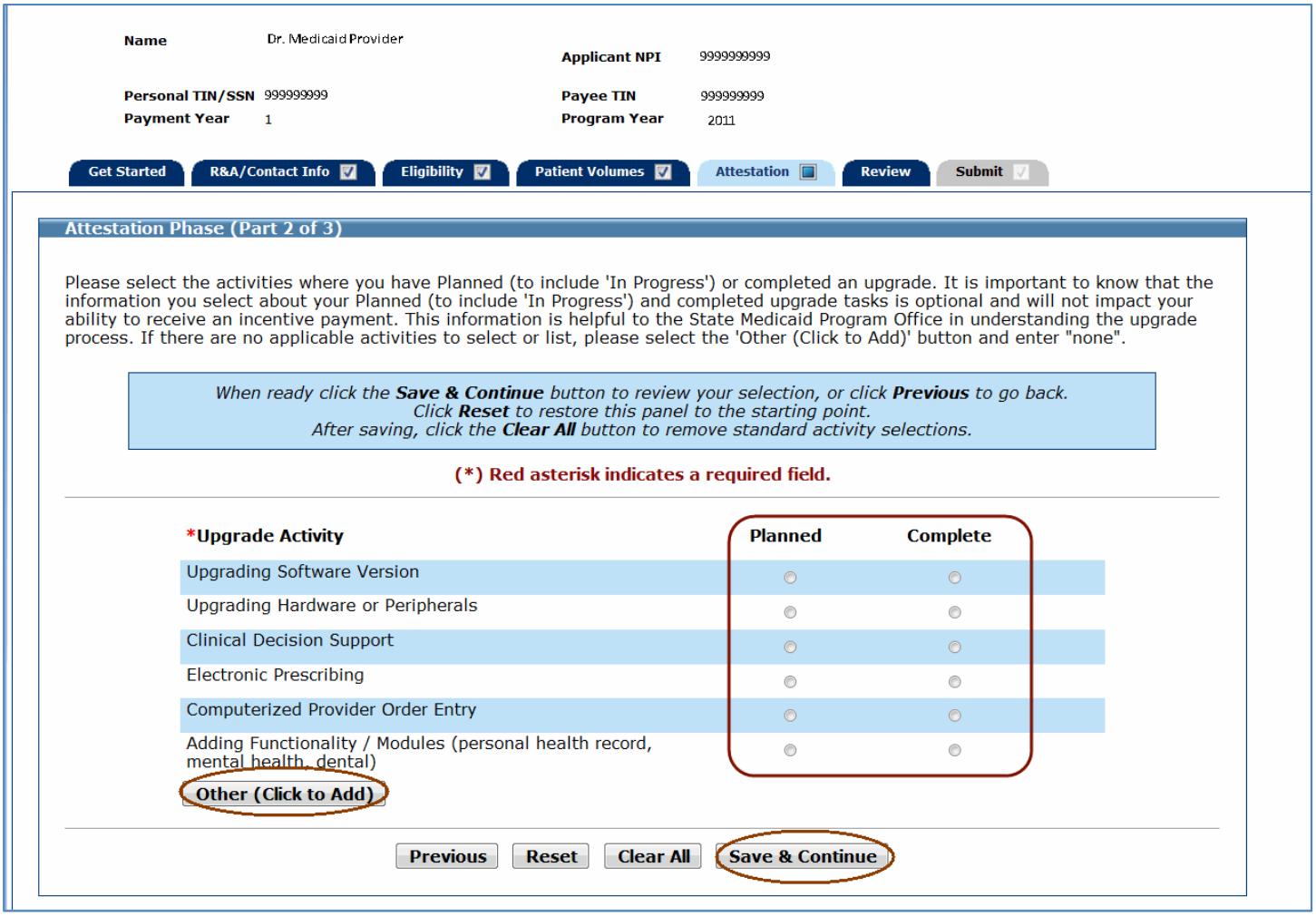
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



Select your **Upgrade Activities** by selecting the **Planned** or **Complete** button for each activity.

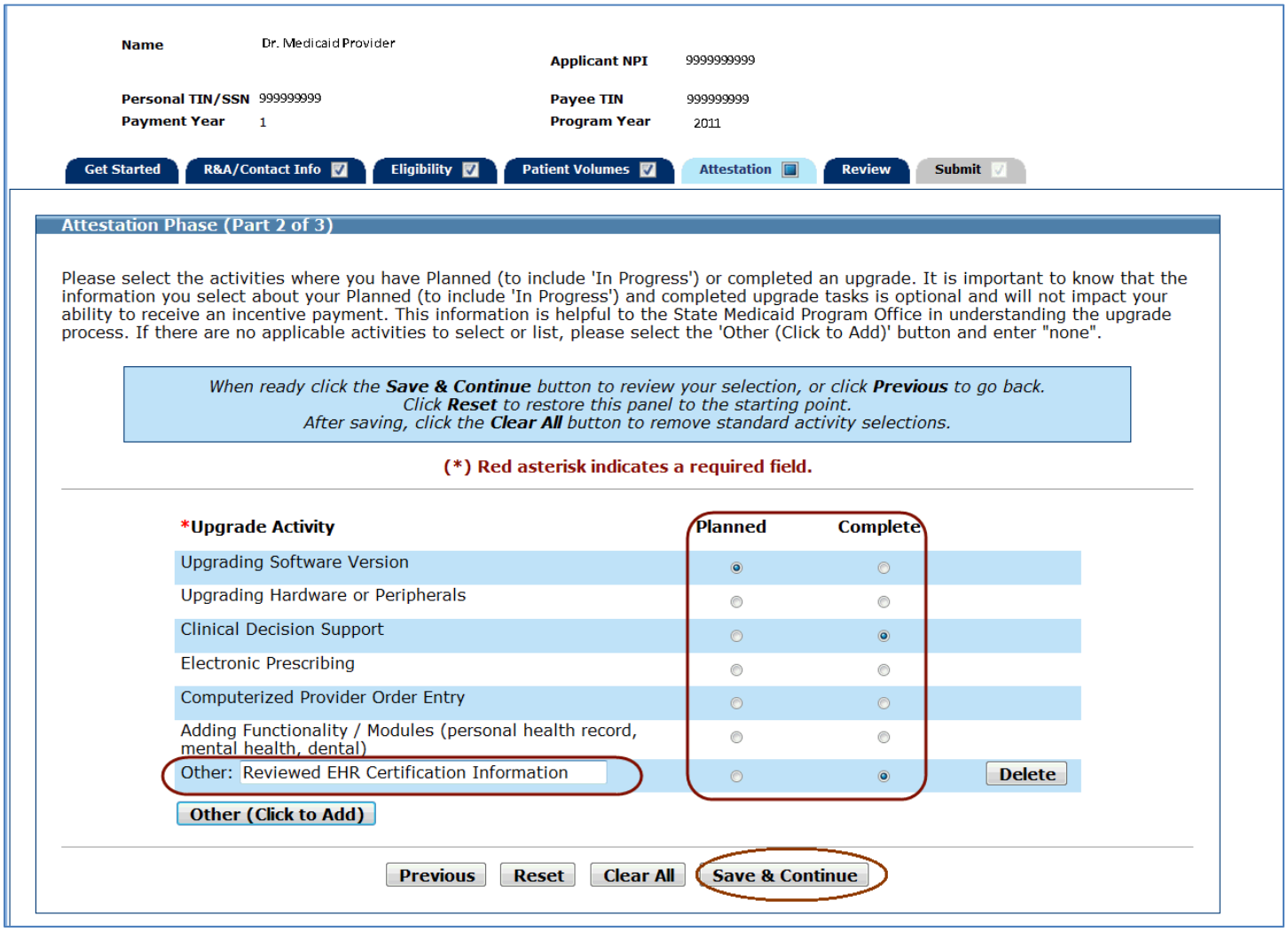
Click **Other** to add any additional **Upgrade Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 2 of 3)
Please select the activities where you have Planned (to include 'In Progress') or completed an upgrade. It is important to know that the information you select about your Planned (to include 'In Progress') and completed upgrade tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the upgrade process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
After saving, click the Clear All button to remove standard activity selections.
(*) Red asterisk indicates a required field.
*Upgrade Activity
Planned
Complete
Upgrading Software Version
Upgrading Hardware or Peripherals
Clinical Decision Support
Electronic Prescribing
Computerized Provider Order Entry
Adding Functionality / Modules (personal health record, mental health, dental)
Other (Click to Add)
Previous
Reset
Clear All
Save & Continue

This screen shows an example of entering activities other than what was in the Upgrade Activity listing.

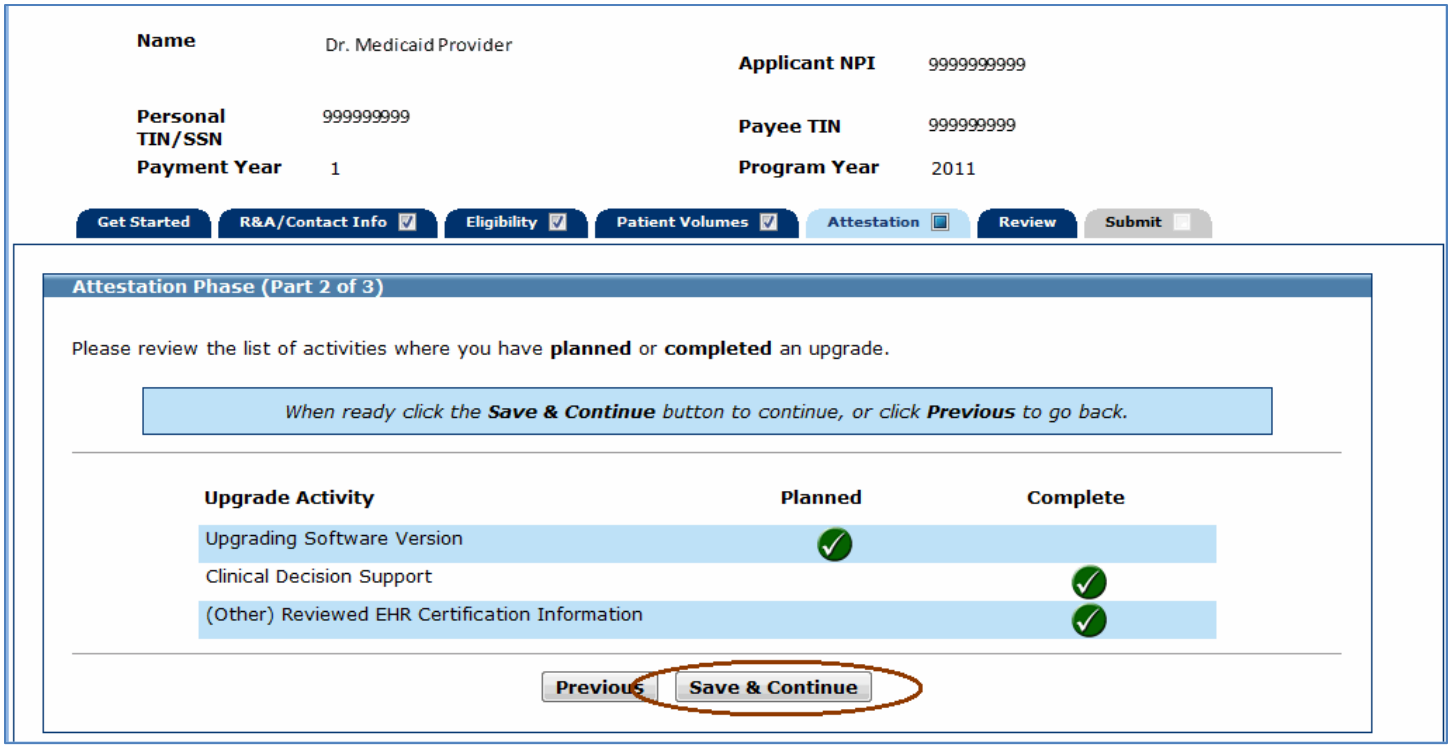
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 2 of 3)
Please select the activities where you have Planned (to include 'In Progress') or completed an upgrade. It is important to know that the information you select about your Planned (to include 'In Progress') and completed upgrade tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the upgrade process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
After saving, click the Clear All button to remove standard activity selections.
(*) Red asterisk indicates a required field.
*Upgrade Activity
Planned
Complete
Upgrading Software Version
Upgrading Hardware or Peripherals
Clinical Decision Support
Electronic Prescribing
Computerized Provider Order Entry
Adding Functionality / Modules (personal health record, mental health, dental)
Other: Reviewed EHR Certification Information
Delete
Other (Click to Add)
Previous
Reset
Clear All
Save & Continue

Review the **Upgrade Activities** you selected.

Click **Save & Continue** to continue, or click **Previous** to go back.

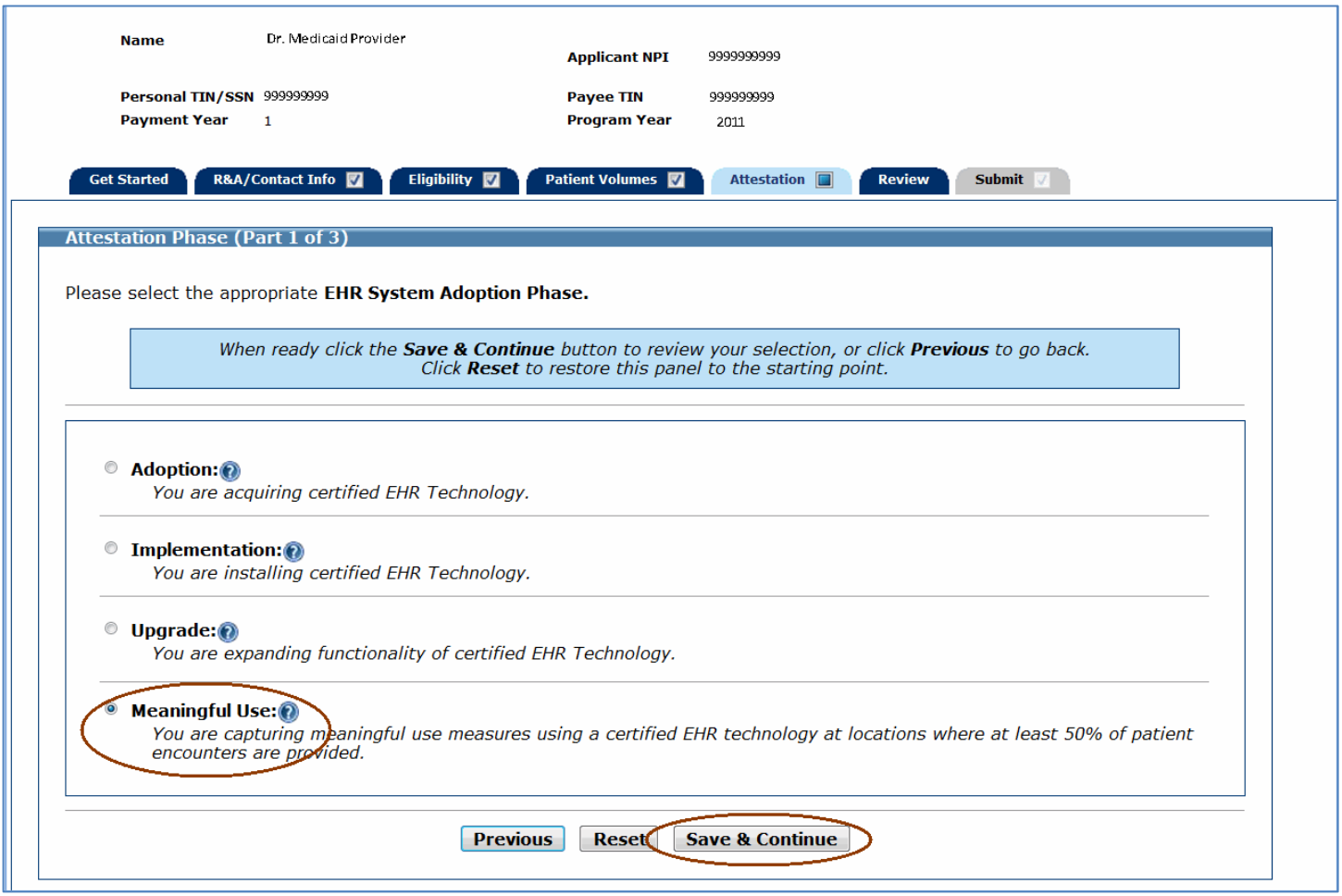
Proceed to page 171 in this guide to continue.



Meaningful Use Phase

For **Meaningful Use** select the Meaningful Use button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



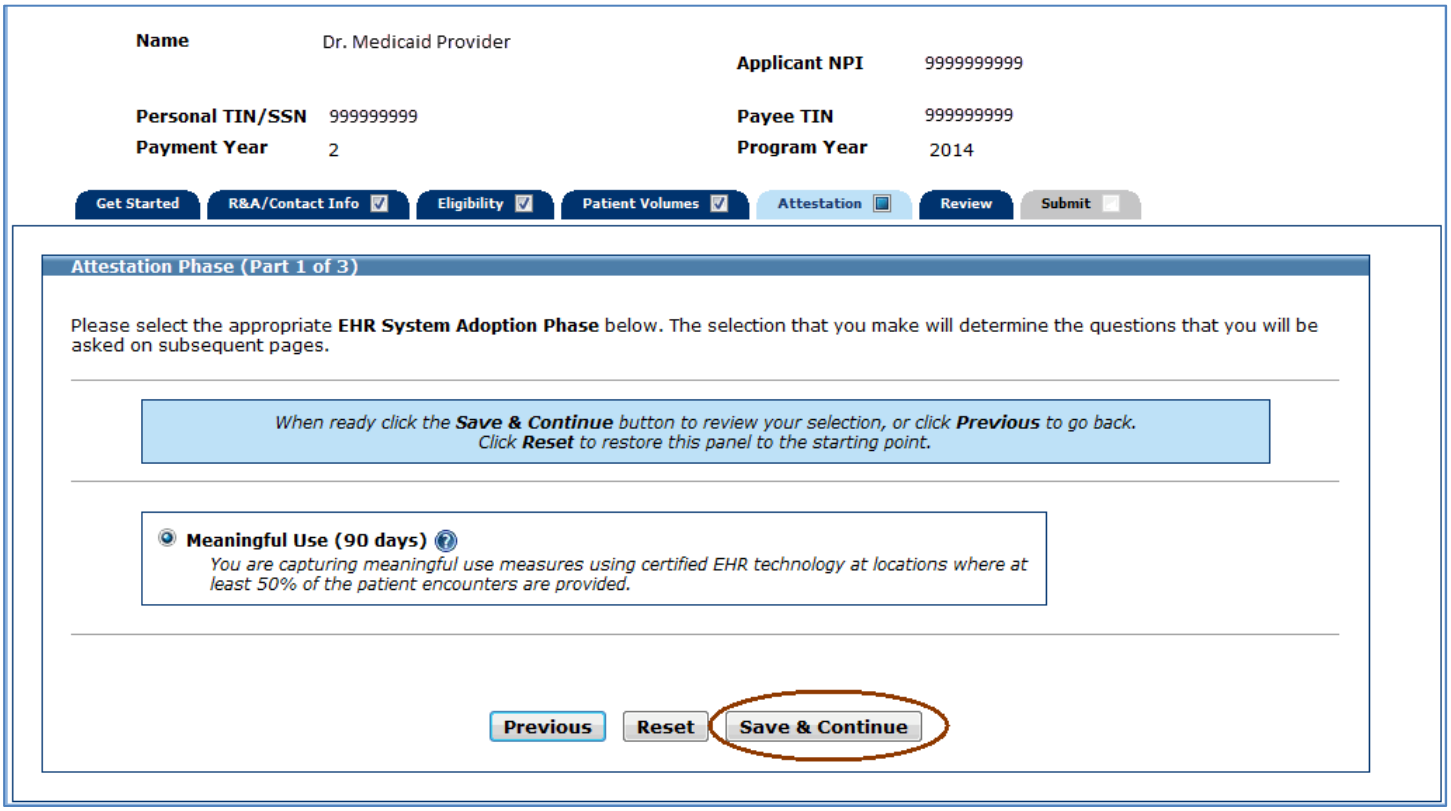
Select an EHR System Adoption Phase for reporting **Meaningful Use of certified EHR technology**. The selections available to you will depend on the Program Year you are in.

If you are in Program Year 2014, you must attest to Meaningful Use (90 days); therefore, the Meaningful Use (Full Year) option will not display. The screen below is an example of this scenario.

If you are in Program Year 2015 or higher and have previously attested to Adoption, Implementation, or Upgrade, you may attest to Meaningful Use (90 days) or Meaningful Use (Full Year).

If you are in Program Year 2015 or higher and you have previously attested to Meaningful Use, you must attest to Meaningful Use (Full Year); therefore, only this option will display.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

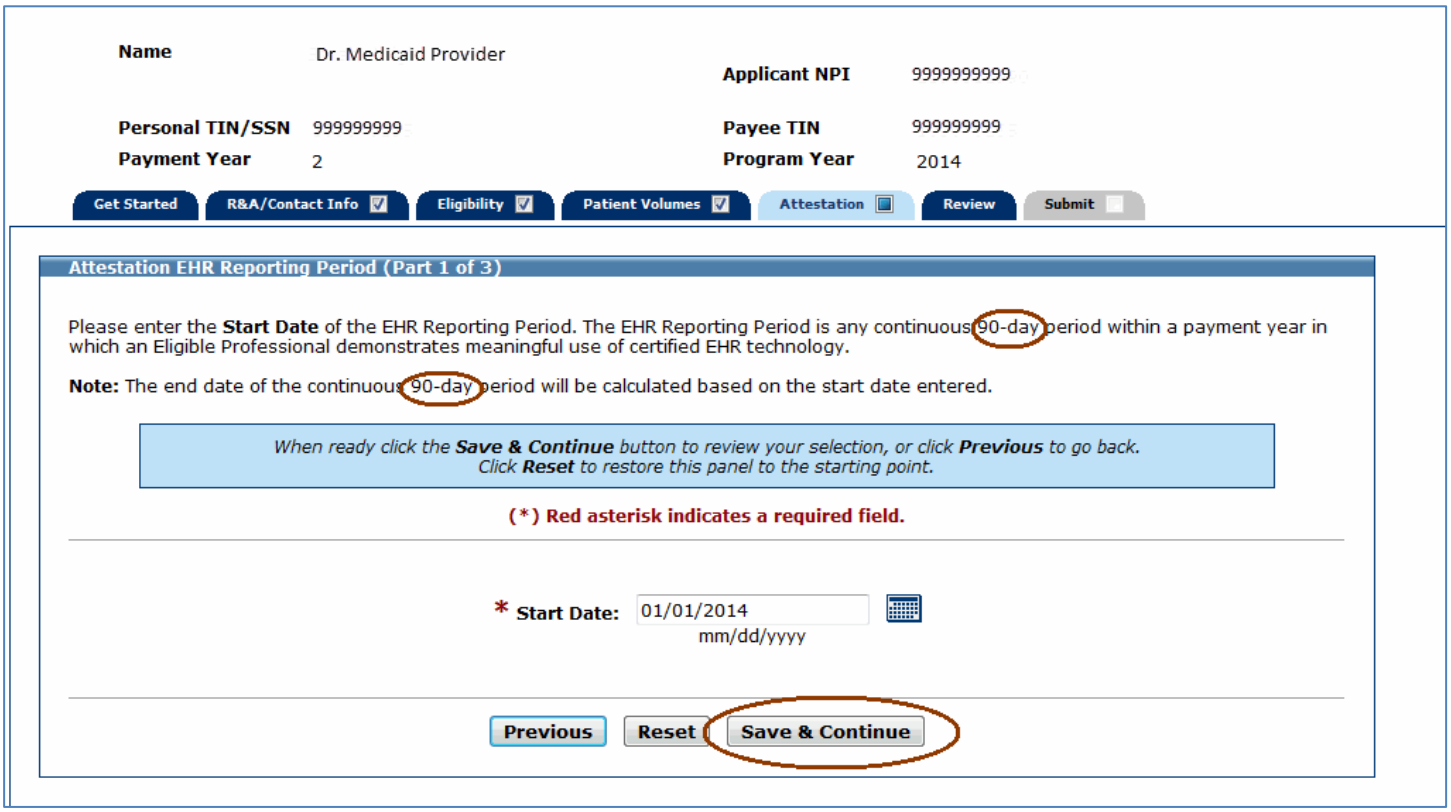

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 1 of 3)
Please select the appropriate EHR System Adoption Phase below. The selection that you make will determine the questions that you will be asked on subsequent pages.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
Meaningful Use (90 days)
You are capturing meaningful use measures using certified EHR technology at locations where at least 50% of the patient encounters are provided.
Previous
Reset
Save & Continue

Depending on the selection made on the previous screen, the Attestation EHR Reporting Period (Part 1 of 3) screen will display with the 90-day period or the full year period. The example below displays the 90-day period for an incentive application in Program Year 2014.

Enter a **Start Date** or use the calendar located to the right of the Start Date field.

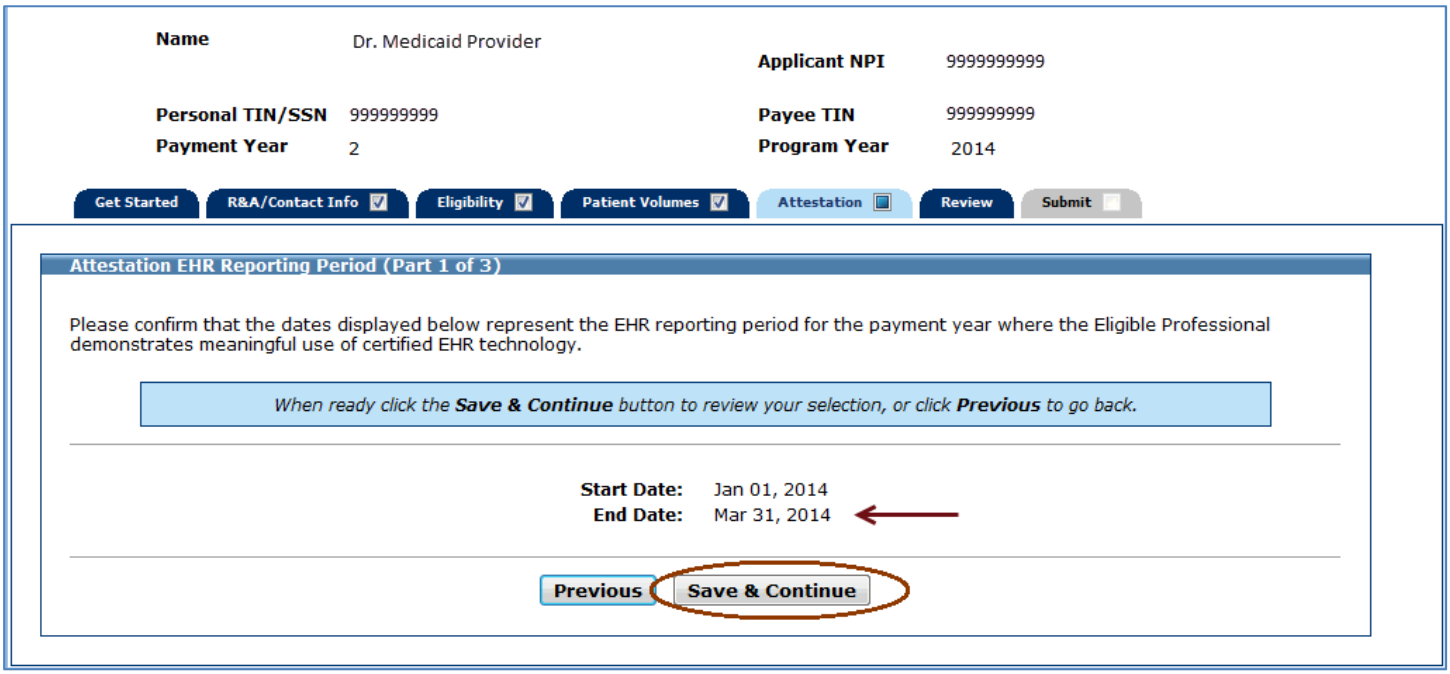
For Program Year 2014, the 90 day EHR reporting period must fall within the Program Year begin and end date range, and not include days in a grace period.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation EHR Reporting Period (Part 1 of 3)
Please enter the Start Date of the EHR Reporting Period. The EHR Reporting Period is any continuous 90-day period within a payment year in which an Eligible Professional demonstrates meaningful use of certified EHR technology.
Note: The end date of the continuous 90-day period will be calculated based on the start date entered.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Start Date:
01/01/2014
mm/dd/yyyy
Previous
Reset
Save & Continue

This screen displays an example of a **Start Date** of January 1, 2014 and a system-calculated **End Date** of March 31, 2014.

Click **Save & Continue** to review your selection, or click **Previous** to go back.



Attestation Meaningful Use Measures

The Medicaid EHR Incentive Program will be implemented in three stages with increasing requirements for participation. All EPs begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of Meaningful Use and a full year in their second year of Meaningful Use (except for Program Year 2014). After meeting the Stage 1 requirements, the EP then has to meet the Stage 2 requirements for two full years. Stage 1 Meaningful Use and Stage 2 Meaningful Use requirements are addressed in different sections of this manual.

The screen on the following page displays the Measures Topic List. The Attestation Meaningful Use Measures are divided into four distinct topics: General Requirements, Core Measures, Menu Measures, and Clinical Quality Measures.

The Clinical Quality Measures are grouped into the following recommended sets.

- General: Lists all 64 Clinical Quality Measures available for attestation
- Adult Set: Lists the Clinical Quality Measures recommended for EPs with an adult population
- Pediatric Set: Lists the Clinical Quality Measures recommended for EPs with a pediatric population

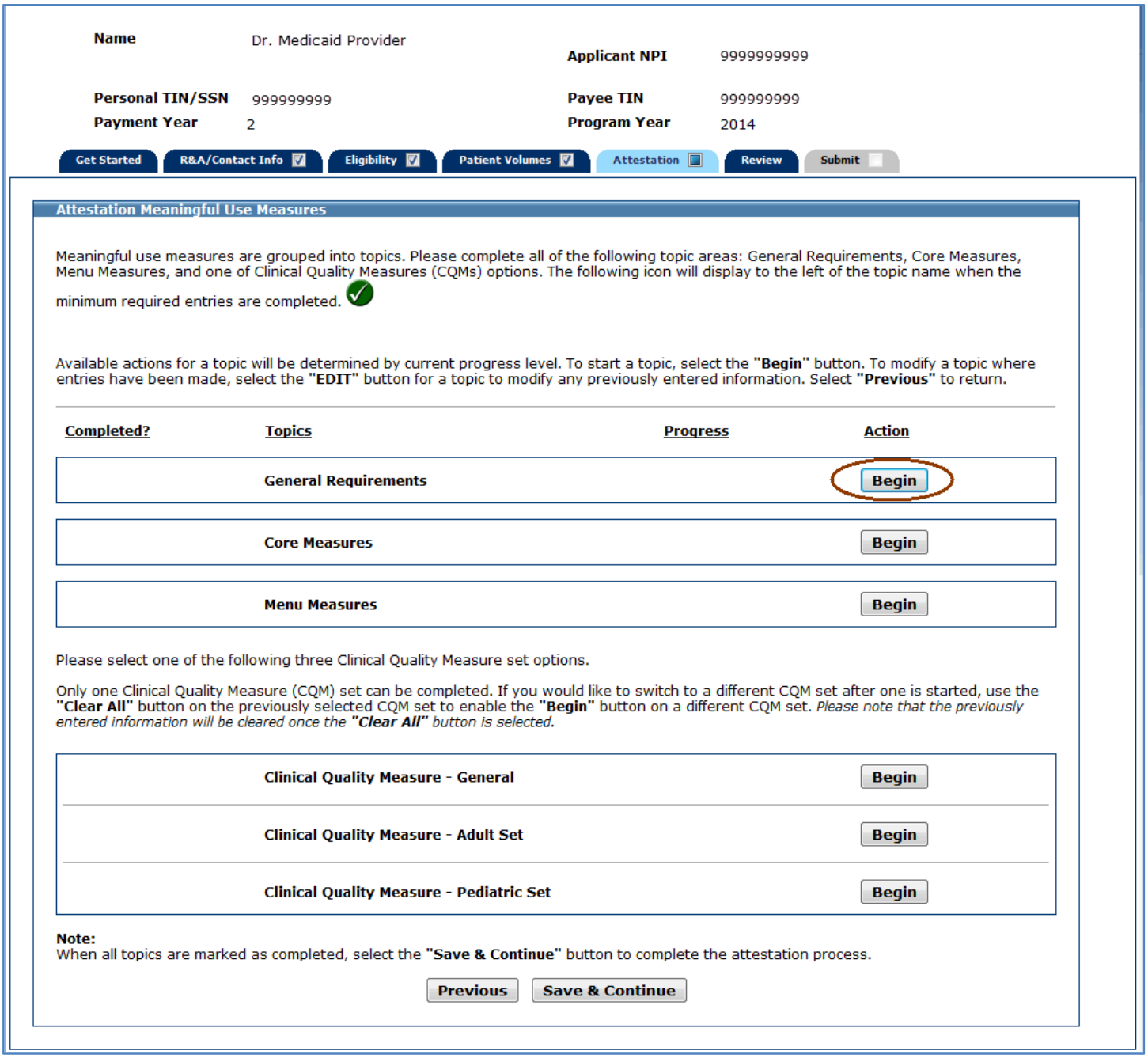
You may select any of the four measure topics and complete them in any order.

While it is not required that you begin each topic in the order shown on the screen, this user guide will follow the order in which the topics are listed.

Click **Begin** to start the General Requirements topic.

If you are in Program Year 2014 and are scheduled to attest to Stage 2 Meaningful Use, MAPIR will allow you to attest to Stage 1 Meaningful Use. This only applies to Program Year 2014.

Also, if you are in Program Year 2014, the stage of attestation that you selected after confirming your CMS EHR Certification ID will determine the Attestation Meaningful Use Measures that will display on the Attestation tab. If you selected the **2013 Stage 1 objectives, measures, and CQM**, turn to page 209 of this guide.

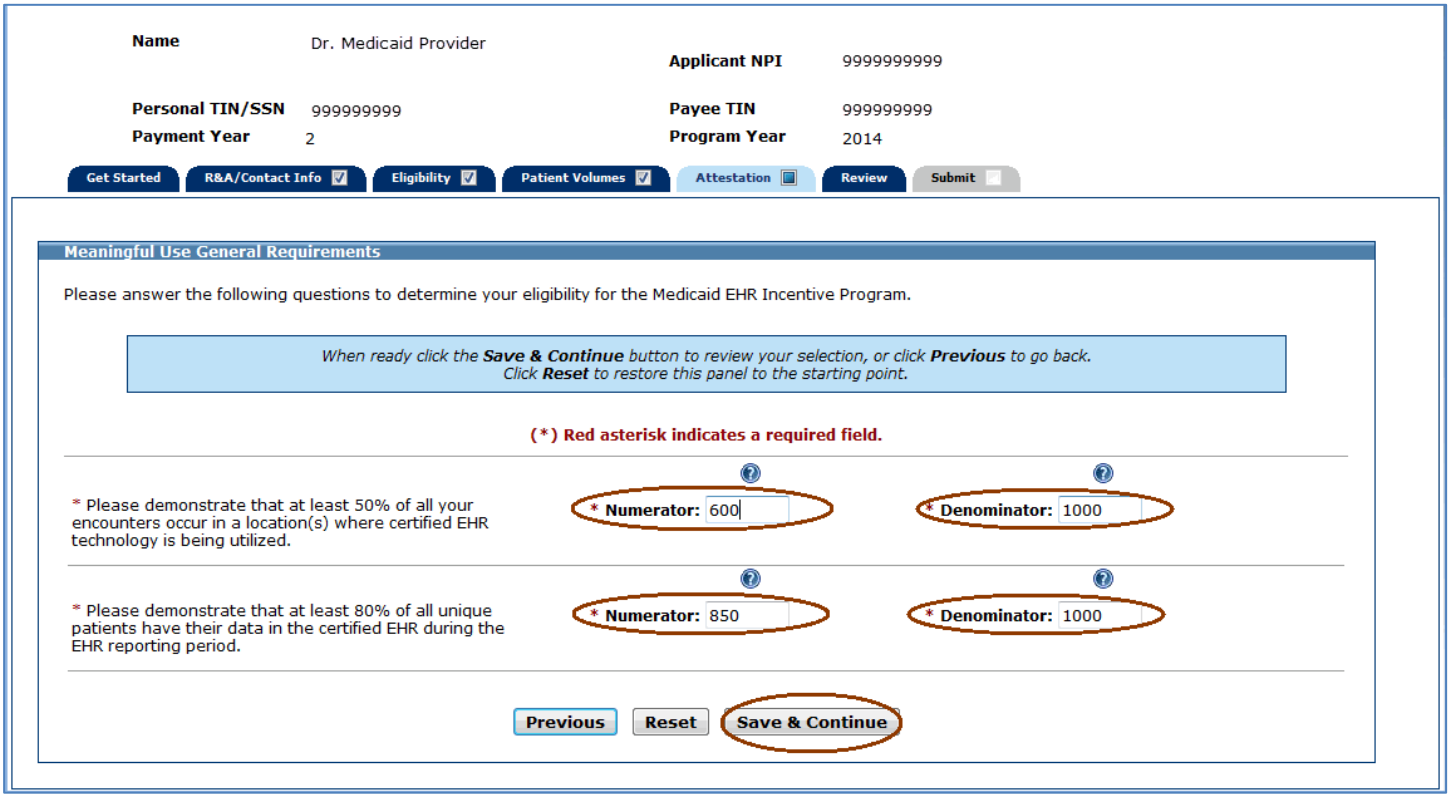

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
Begin
Core Measures
Begin
Menu Measures
Begin
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
Begin
Clinical Quality Measure - Adult Set
Begin
Clinical Quality Measure - Pediatric Set
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use General Requirements

Enter information in all required fields.

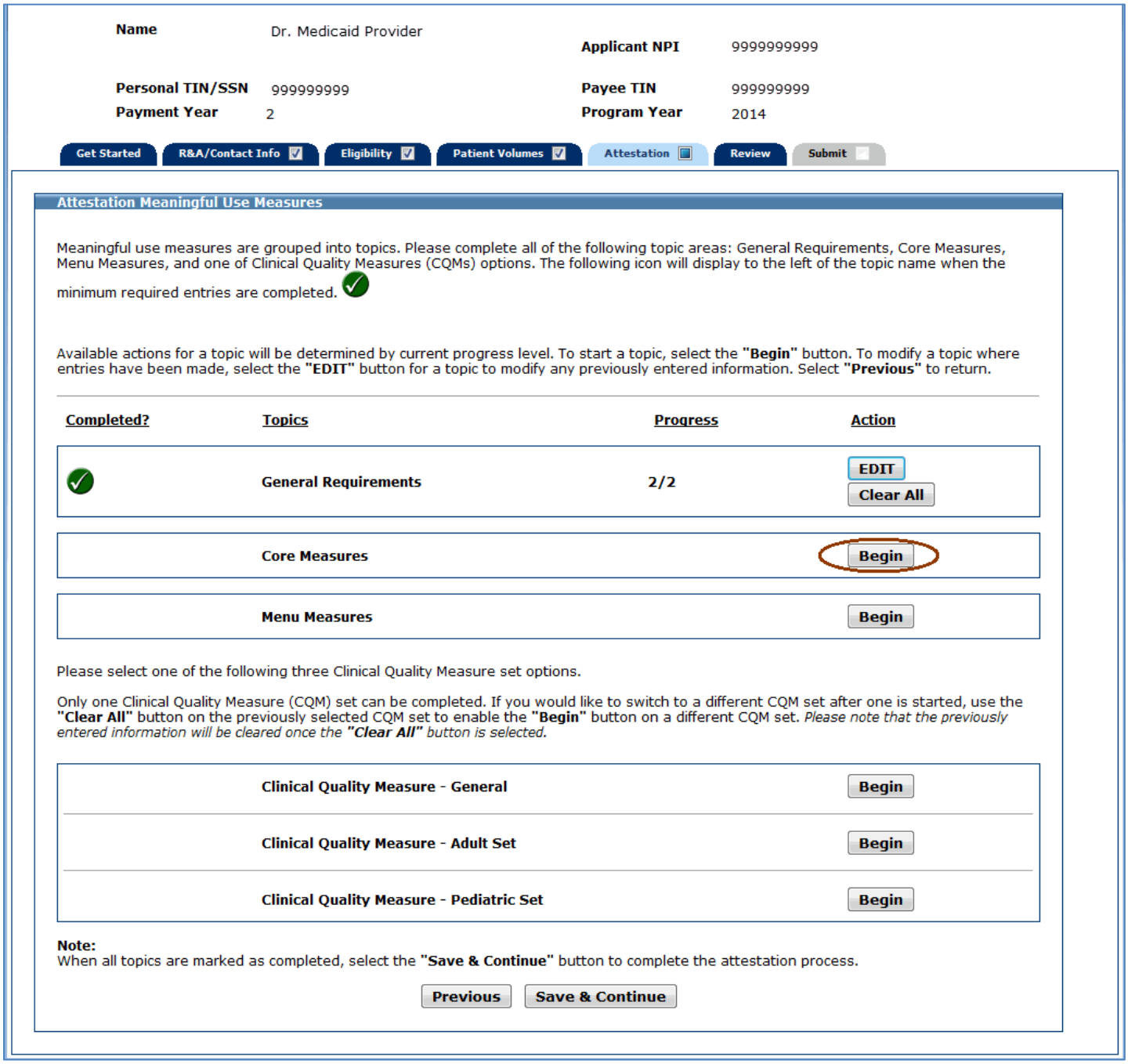
The denominator entered must be greater than or equal to the numerator entered. The numerator and denominator entries must be positive whole numbers.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Meaningful Use General Requirements
Please answer the following questions to determine your eligibility for the Medicaid EHR Incentive Program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.
* Numerator: 600
* Denominator: 1000
* Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.
* Numerator: 850
* Denominator: 1000
Previous
Reset
Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, or click **Clear All** to clear the topic information you entered. Click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
Begin
Menu Measures
Begin
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
Begin
Clinical Quality Measure - Adult Set
Begin
Clinical Quality Measure - Pediatric Set
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

If you are in Meaningful Use Stage 1, proceed to the next page.

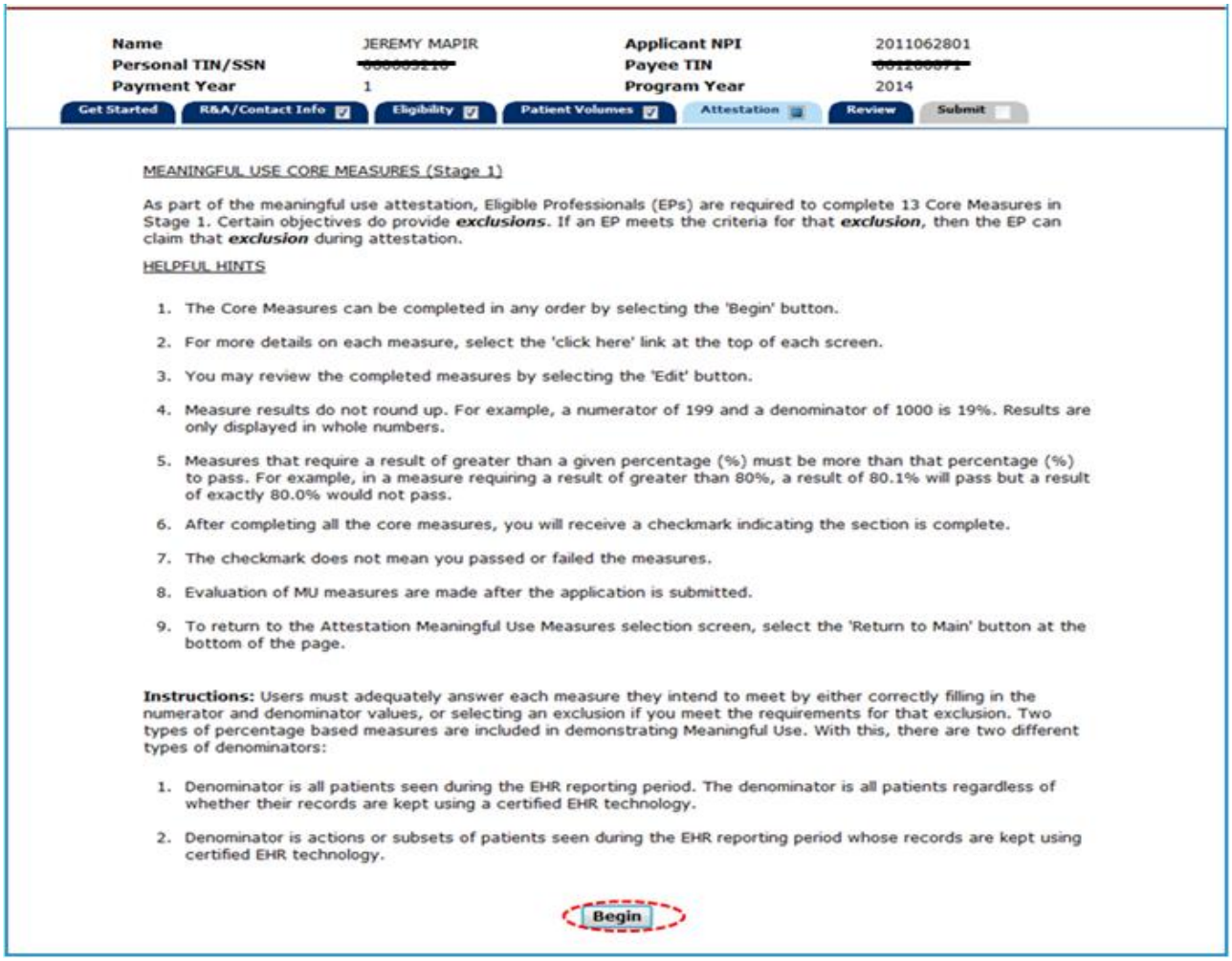
If you are in Meaningful Use Stage 2, proceed to page 118.

Stage 1

Meaningful Use Core Measures

This screen provides information about the Meaningful Use Core Measures for Stage 1.

Click **Begin** to continue to the Meaningful Use Core Measure List Table.

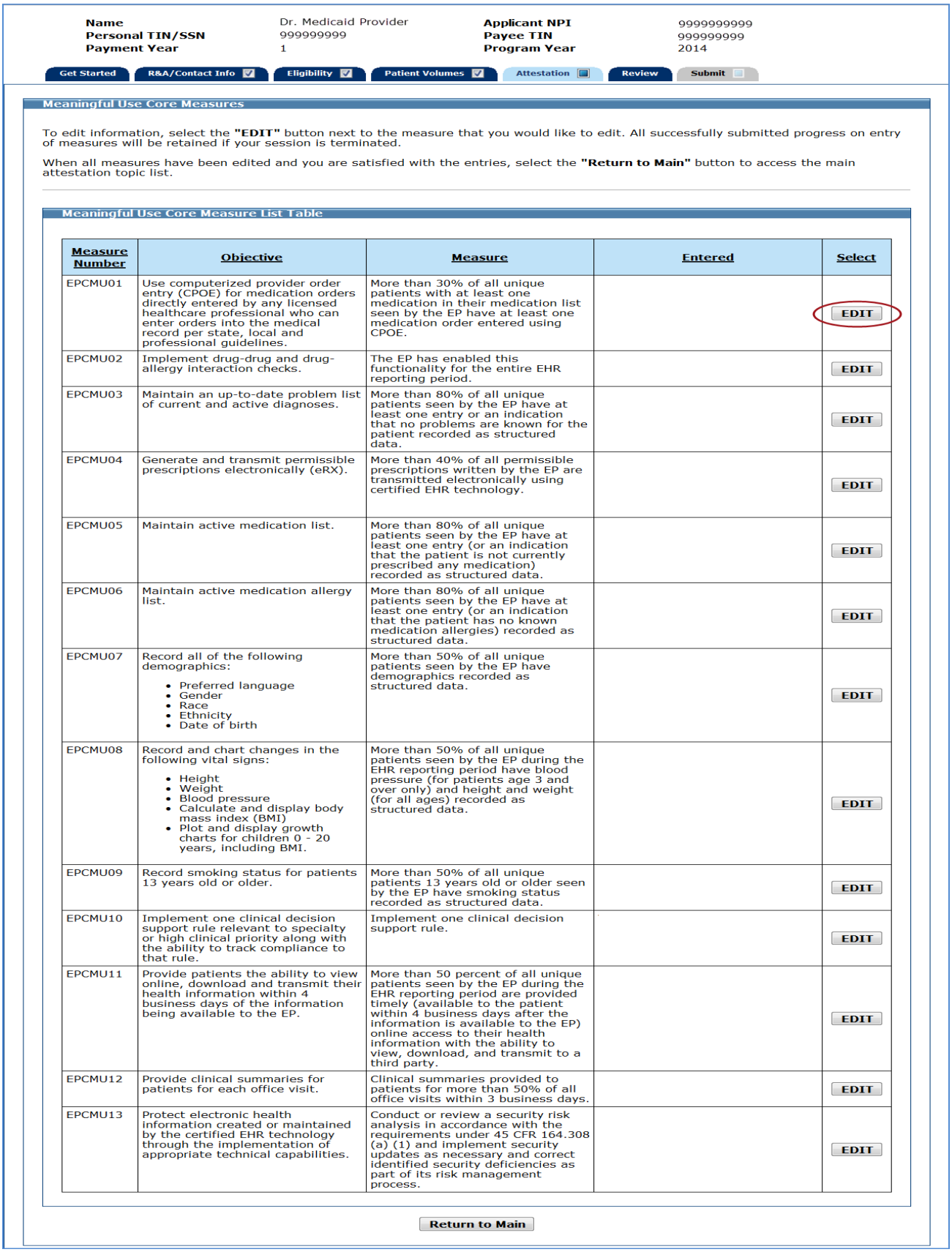

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE CORE MEASURES (Stage 1)
As part of the meaningful use attestation, Eligible Professionals (EPs) are required to complete 13 Core Measures in Stage 1. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation.
HELPFUL HINTS
1. The Core Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.1% will pass but a result of exactly 80.0% would not pass.
6. After completing all the core measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Instructions: Users must adequately answer each measure they intend to meet by either correctly filling in the numerator and denominator values, or selecting an exclusion if you meet the requirements for that exclusion. Two types of percentage based measures are included in demonstrating Meaningful Use. With this, there are two different types of denominators:
1. Denominator is all patients seen during the EHR reporting period. The denominator is all patients regardless of whether their records are kept using a certified EHR technology.
2. Denominator is actions or subsets of patients seen during the EHR reporting period whose records are kept using certified EHR technology.
Begin

The screen on the following page displays the Meaningful Use Core Measure List Table.

The first time a topic is accessed you will see an **Edit** option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for a measure, or click **Return to Main** to return to the Measures Topic List.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
Personal TIN/SSN	999999999	**Payee TIN**	999999999
Payment Year	1	**Program Year**	2014

Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

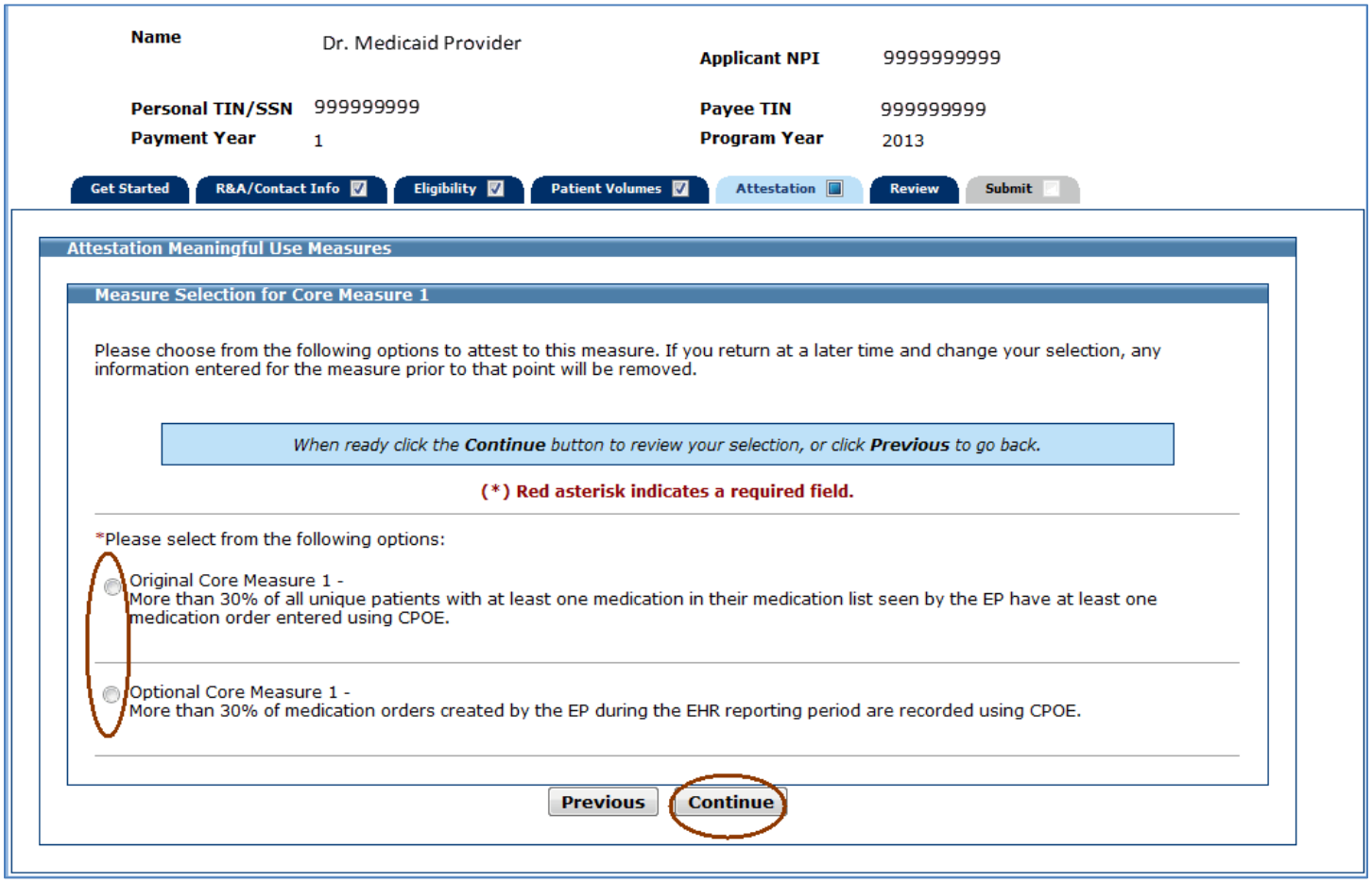
Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.		EDIT
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.		EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.		EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.		EDIT
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.		EDIT
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.		EDIT
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.		EDIT
EPCMU08	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children 0 - 20 years, including BMI.	More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.		EDIT
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.		EDIT
EPCMU10	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.		EDIT
EPCMU11	Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information with the ability to view, download, and transmit to a third party.		EDIT
EPCMU12	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.		EDIT
EPCMU13	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.		EDIT

Return to Main

Measure Selection for Core Measure 1 (Measure Code EPCMU01)

Core Measure 1 has two options, **Original Core Measure 1** or **Optional Core Measure 1**. On the Measure Selection for Core Measure 1 screen, choose if you would like to attest to the **Original Core Measure 1** or the **Optional Core Measure 1.** If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

Click **Continue** to proceed to the appropriate core measure screen for the option you selected, or click **Previous** to go back.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Measure Selection for Core Measure 1
Please choose from the following options to attest to this measure. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.
When ready click the Continue button to review your selection, or click Previous to go back.
(*) Red asterisk indicates a required field.
*Please select from the following options:
Original Core Measure 1 -
More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Optional Core Measure 1 -
More than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
Previous
Continue

The following is a list of the 14 Meaningful Use Core Measures that you must attest to (Core Measure 1 has two versions to choose from).

Click on the Screen Example to see an example of the screen layout.

Meaningful Use Core Measure	Screen Example
Core Measure 1 - CPOE for Medication Orders Original	Screen 1
Core Measure 1 - CPOE for Medication Orders Optional	Screen 1
Core Measure 2 - Drug Interaction Checks	Screen 2
Core Measure 3 - Maintain Problem List	Screen 3
Core Measure 4 - ePrescribing (eRx)	Screen 4
Core Measure 5 - Active Medication List	Screen 3
Core Measure 6 - Medication Allergy List	Screen 3
Core Measure 7 - Record Demographics	Screen 3
Core Measure 8 - Record Vital Signs	Screen 4
Core Measure 9 - Record Smoking Status	Screen 1
Core Measure 10 - Clinical Decision Support Rule	Screen 2
Core Measure 11 - Patient Electronic Access	Screen 1
Core Measure 12 - Clinical Summaries	Screen 1
Core Measure 13 - Protect Electronic Health Information	Screen 2

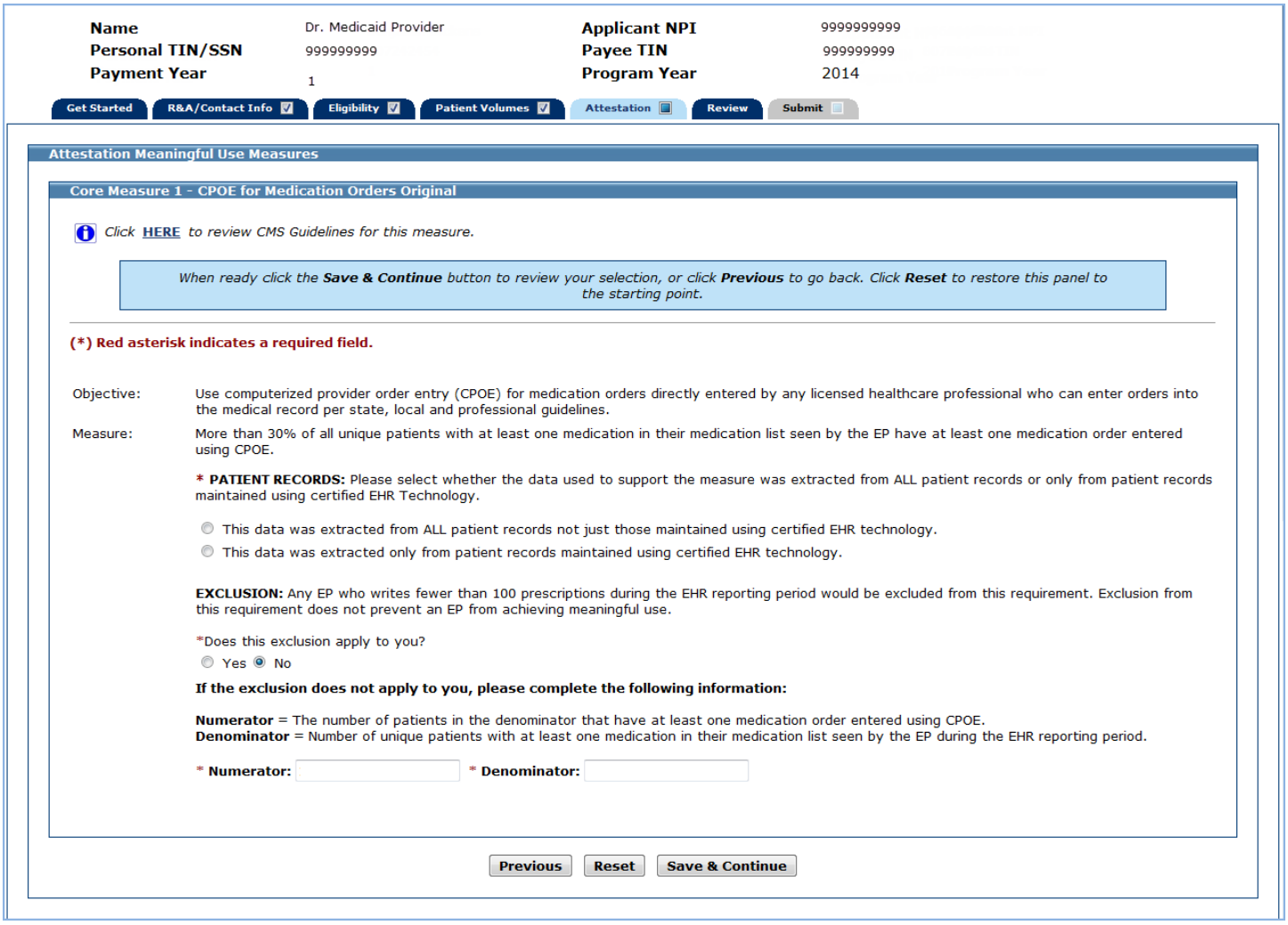
There are 14 Meaningful Use Core Measure screens (Core Measure 1 has two screens to choose from). As you proceed through the Meaningful Use Core Measure section of MAPIR, you will see four different screen layouts. Instructions for each measure are provided on the screen. For additional help with a specific Meaningful Use Core Measure, click on the link provided above the blue instruction box.

Screen layout examples are shown below.

Screen 1

The following Meaningful Use Core Measures use this screen layout:

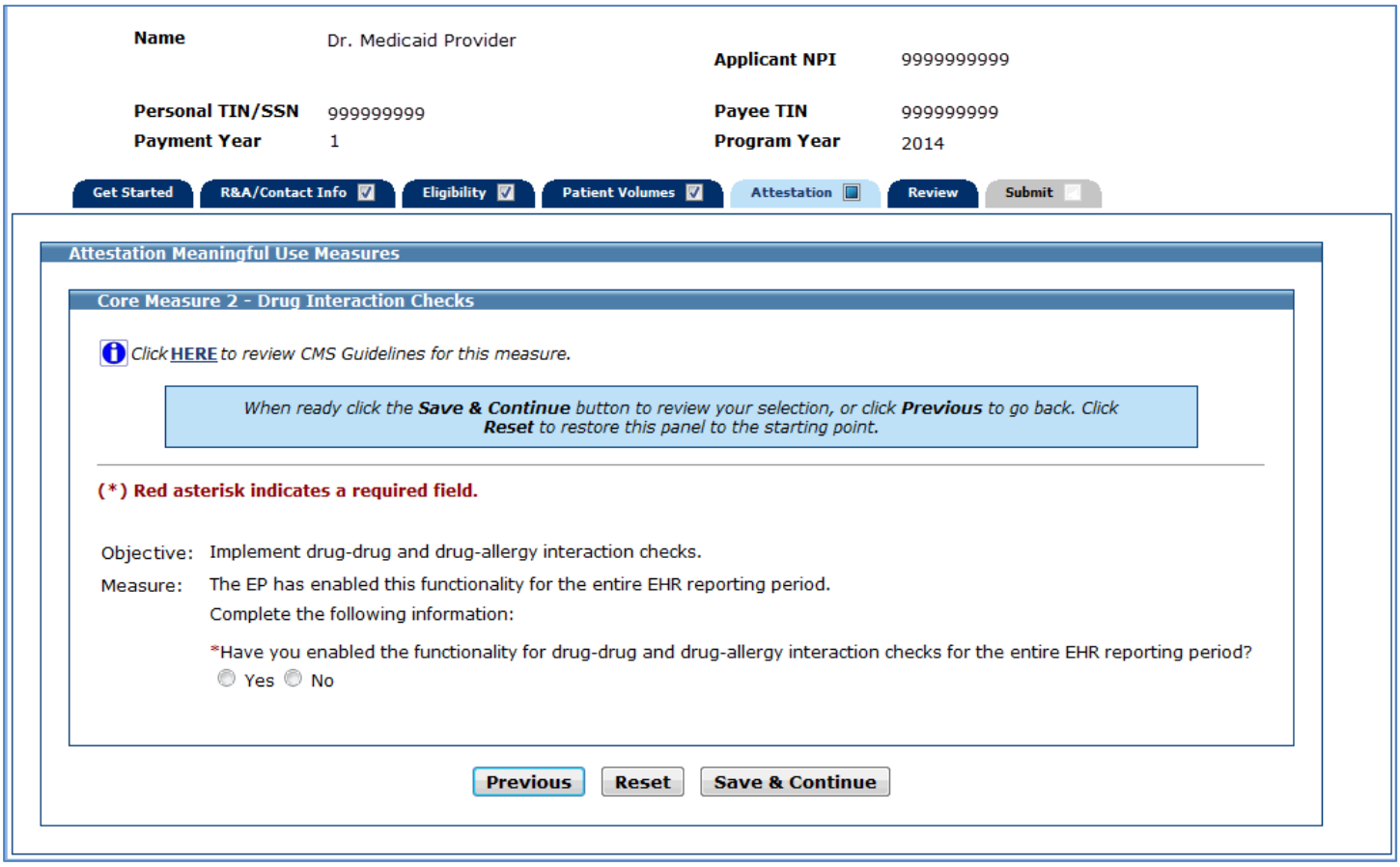
Core Measures 1 (Original and Optional), 8, 9, 11, and 12


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 1 - CPOE for Medication Orders Original
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Measure:
More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply to you, please complete the following information:
Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator = Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Core Measures use this screen layout:

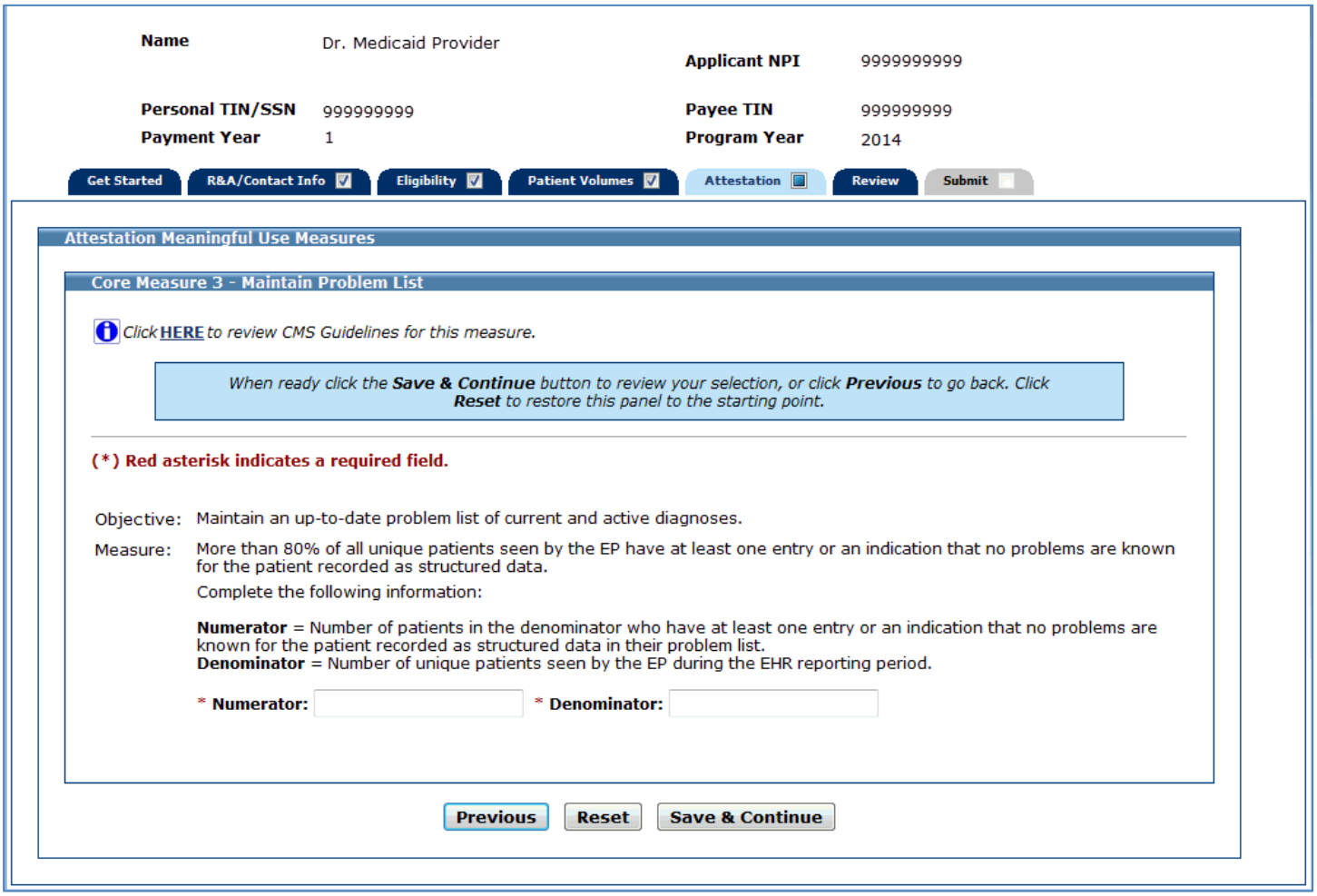
Core Measures 2, 10, and 13


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 2 - Drug Interaction Checks
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Implement drug-drug and drug-allergy interaction checks.
Measure: The EP has enabled this functionality for the entire EHR reporting period.
Complete the following information:
*Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?
Yes
No
Previous
Reset
Save & Continue

Screen 3

The following Meaningful Use Core Measures use this screen layout:

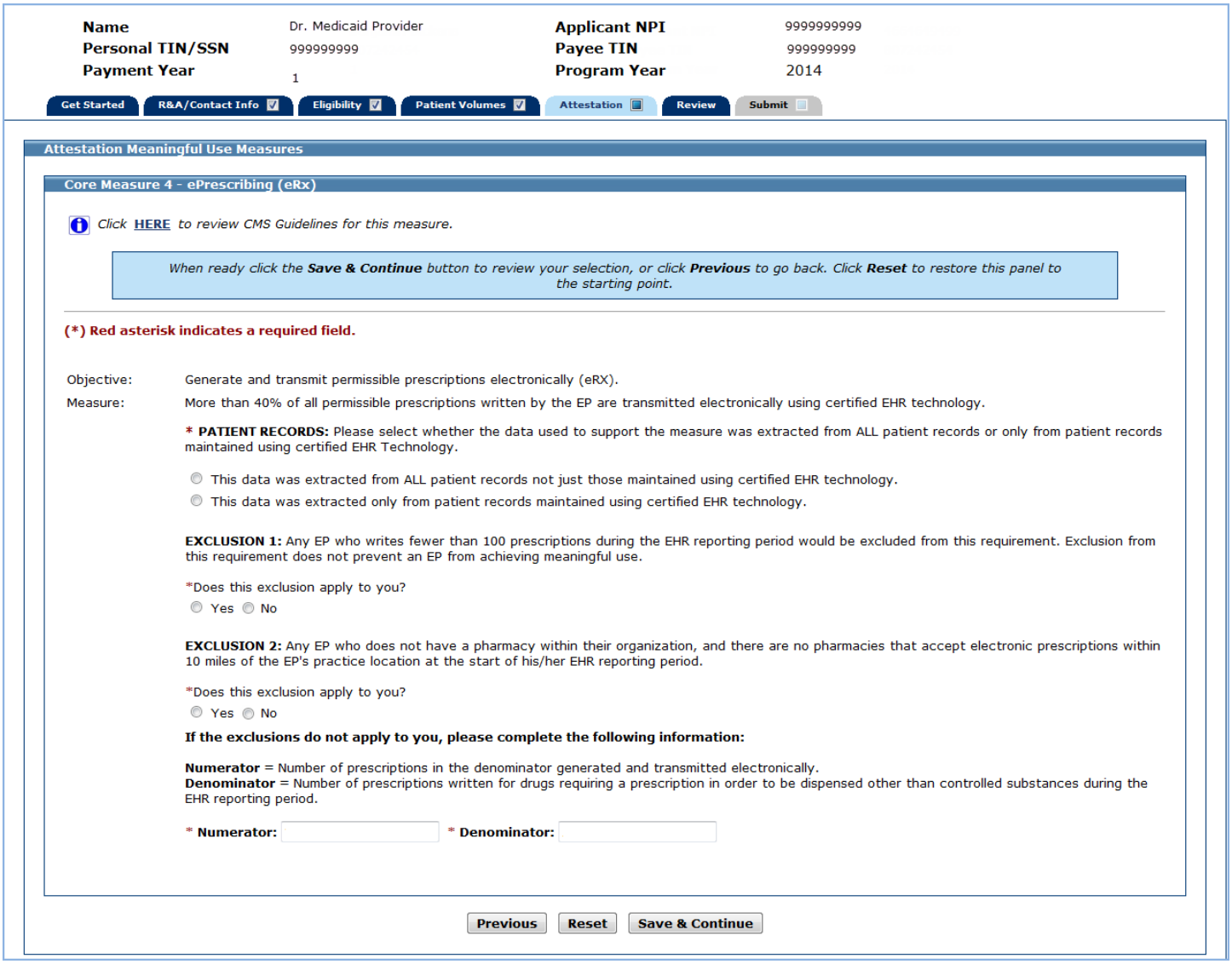
Core Measures 3, 5, 6, and 7


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 3 - Maintain Problem List
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Maintain an up-to-date problem list of current and active diagnoses.
Measure:
More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Complete the following information:
Numerator = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 4

The following Meaningful Use Core Measures use this screen layout:

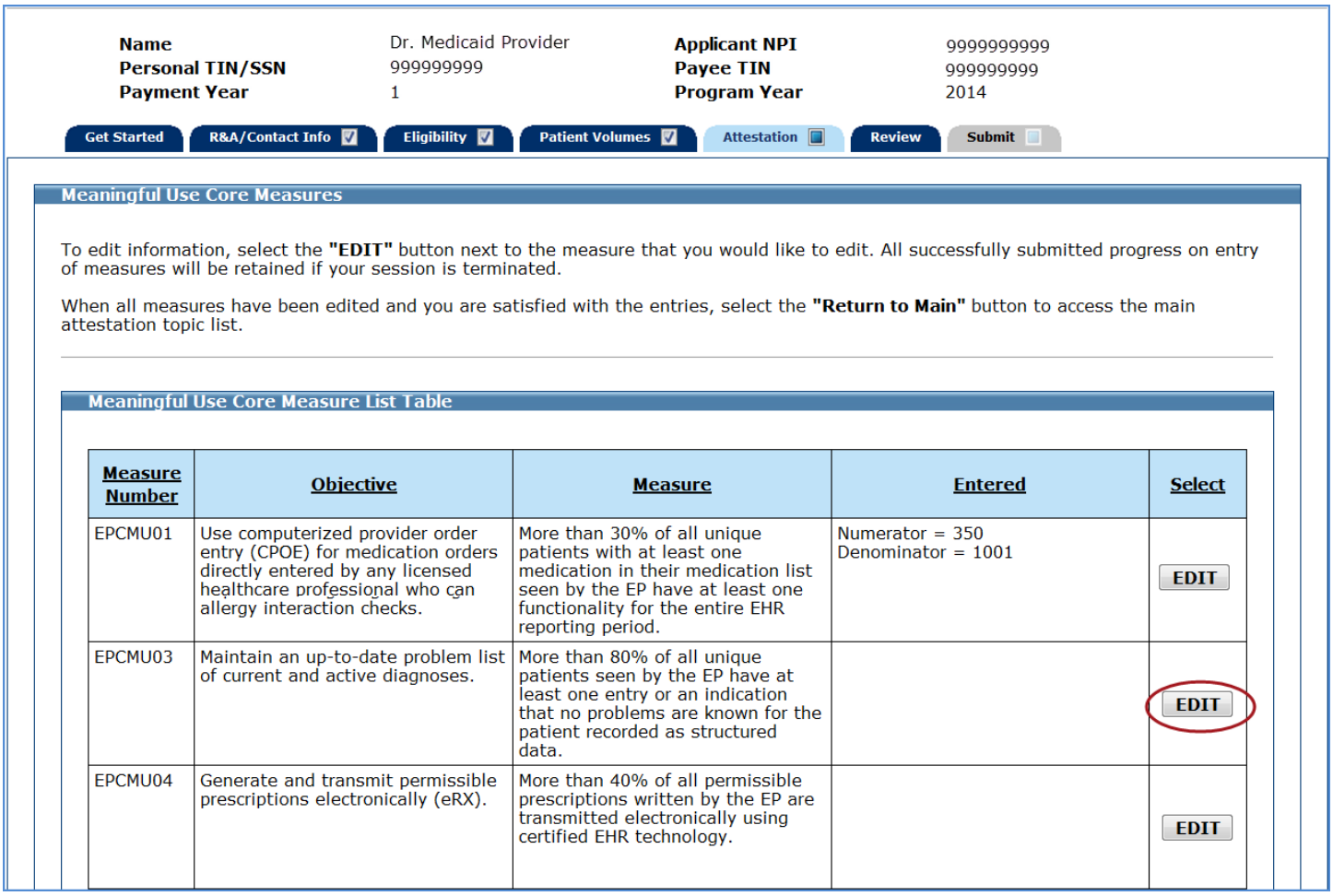
Core Measures 4 and 8


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 4 - ePrescribing (eRx)
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Generate and transmit permissible prescriptions electronically (eRX).
Measure:
More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION 1: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
EXCLUSION 2: Any EP who does not have a pharmacy within their organization, and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
*Does this exclusion apply to you?
Yes No
If the exclusions do not apply to you, please complete the following information:
Numerator = Number of prescriptions in the denominator generated and transmitted electronically.
Denominator = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

After you enter information for a measure, click the **Save & Continue** button. You will return to the Meaningful Use Core Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below. (Please note that the entire screen is not displayed in this example.)

You can continue to edit the measures at any point prior to submitting the application.

Click **Edit** for the next measure.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
Personal TIN/SSN	999999999	**Payee TIN**	999999999
Payment Year	1	**Program Year**	2014

Get Started | R&A/Contact Info ☑ | Eligibility ☑ | Patient Volumes ☑ | Attestation | Review | Submit

Meaningful Use Core Measures

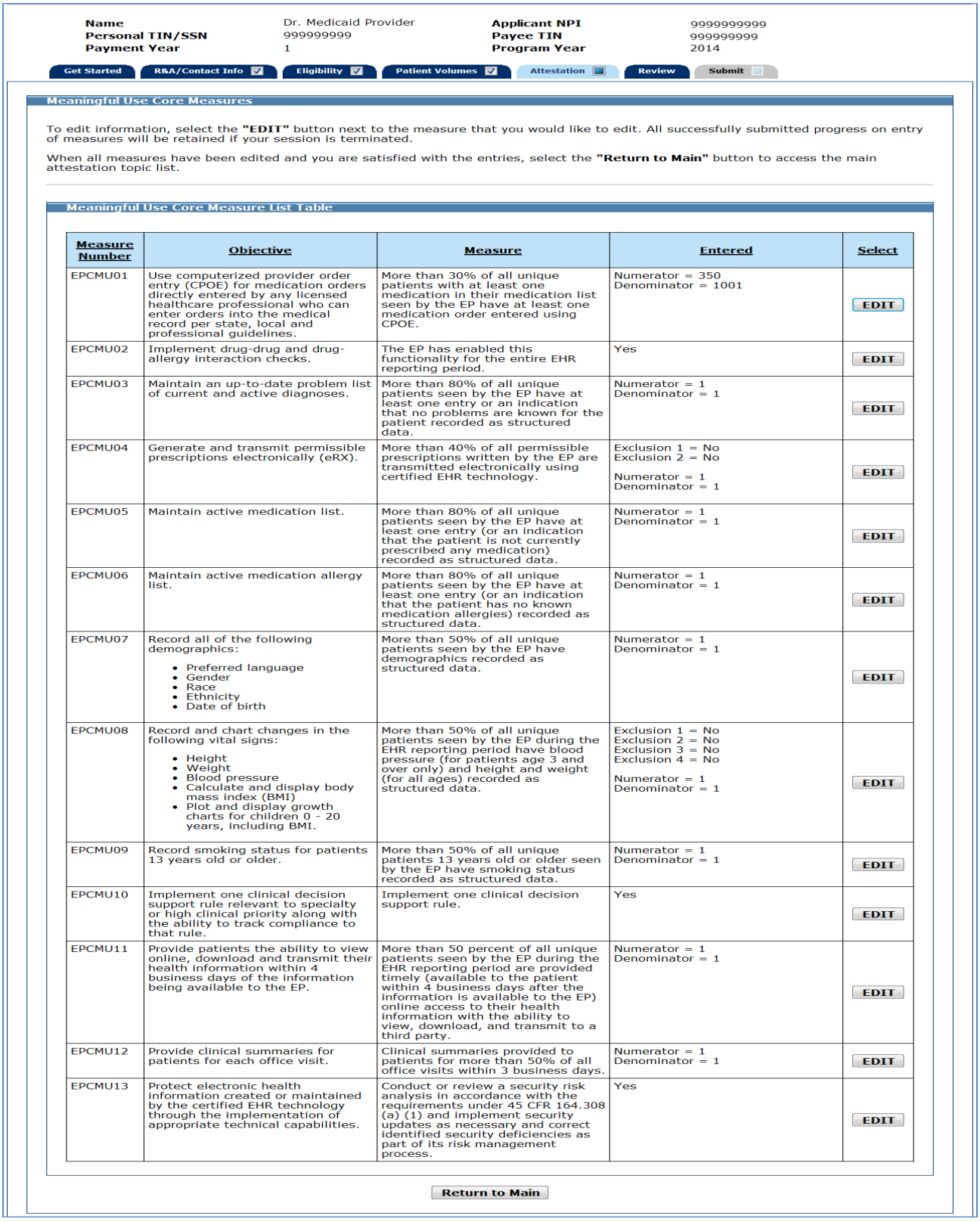
To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can allergy interaction checks.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one functionality for the entire EHR reporting period.	Numerator = 350 Denominator = 1001	EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.		EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.		EDIT

Once you have attested to all the measures for this topic, click **Return to Main** to return to the Measures Topic List.



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Payment Year	1	**Program Year**	2014

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Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

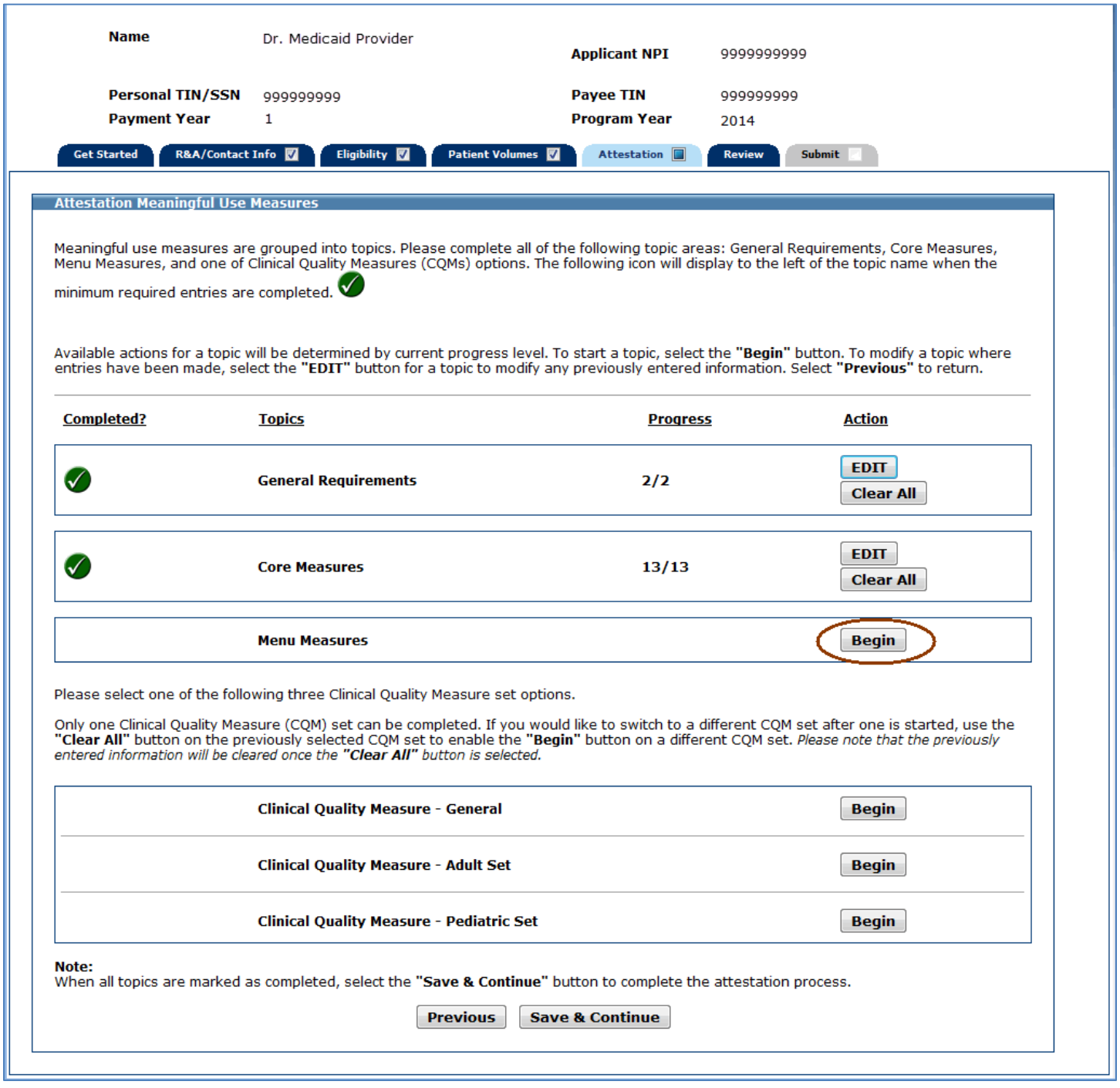
Meaningful Use Core Measure List Table

Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Numerator = 350 Denominator = 1001	EDIT
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	Yes	EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator = 1 Denominator = 1	EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Exclusion 1 = No Exclusion 2 = No Numerator = 1 Denominator = 1	EDIT
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator = 1 Denominator = 1	EDIT
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator = 1 Denominator = 1	EDIT
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	Numerator = 1 Denominator = 1	EDIT
EPCMU08	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children 0 - 20 years, including BMI.	More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	Exclusion 1 = No Exclusion 2 = No Exclusion 3 = No Exclusion 4 = No Numerator = 1 Denominator = 1	EDIT
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Numerator = 1 Denominator = 1	EDIT
EPCMU10	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.	Yes	EDIT
EPCMU11	Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information with the ability to view, download, and transmit to a third party.	Numerator = 1 Denominator = 1	EDIT
EPCMU12	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Numerator = 1 Denominator = 1	EDIT
EPCMU13	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	EDIT

Return to Main

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, or click **Clear All** to clear the topic information you entered. Click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
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999999999
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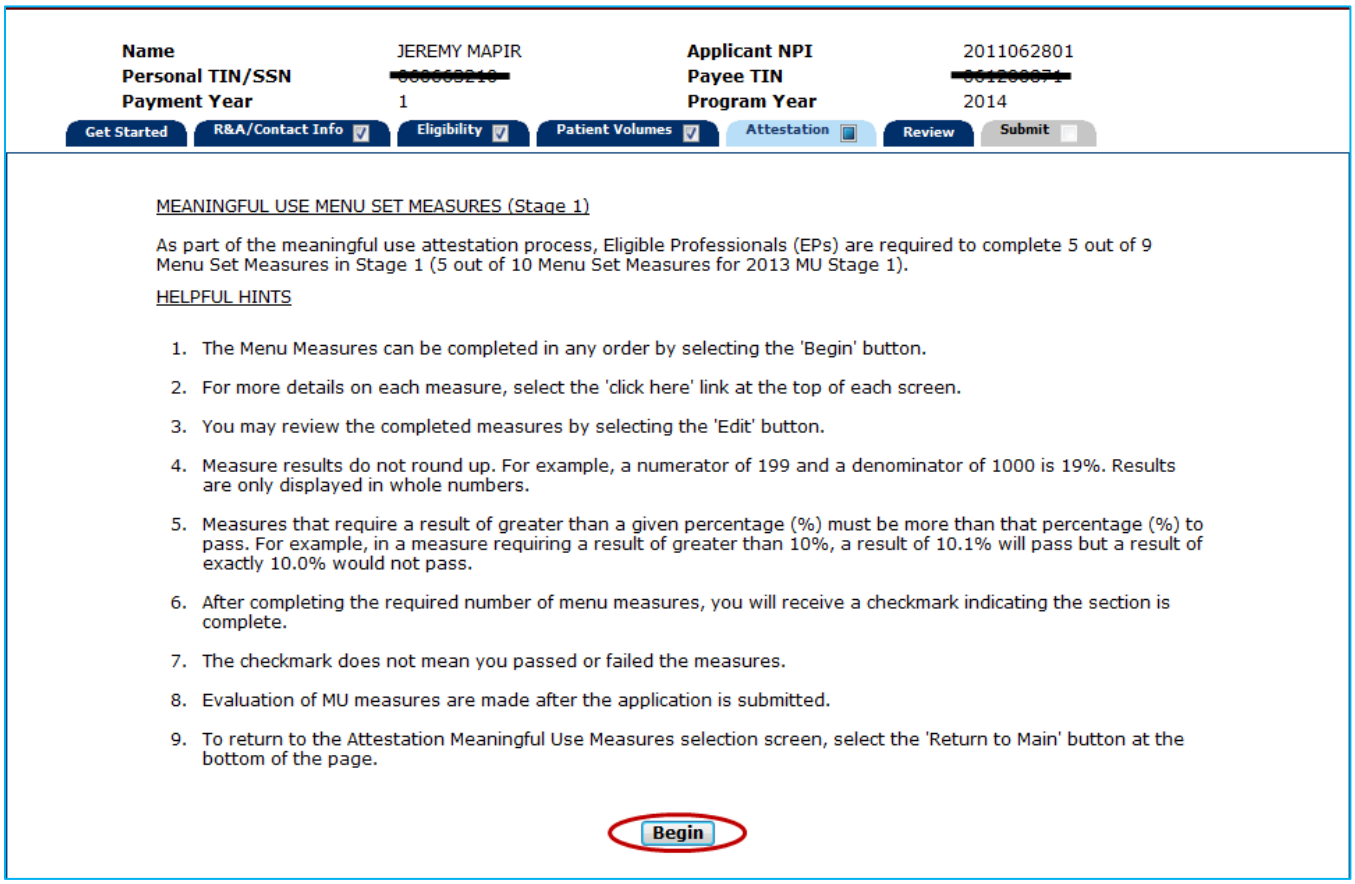
Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
13/13
EDIT
Clear All
Menu Measures
Begin
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
Begin
Clinical Quality Measure - Adult Set
Begin
Clinical Quality Measure - Pediatric Set
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Menu Measures

This initial screen provides information about the Meaningful Use Menu Measures for Stage 1.

Click **Begin** to continue to the Meaningful Use Menu Measures Selection screen.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
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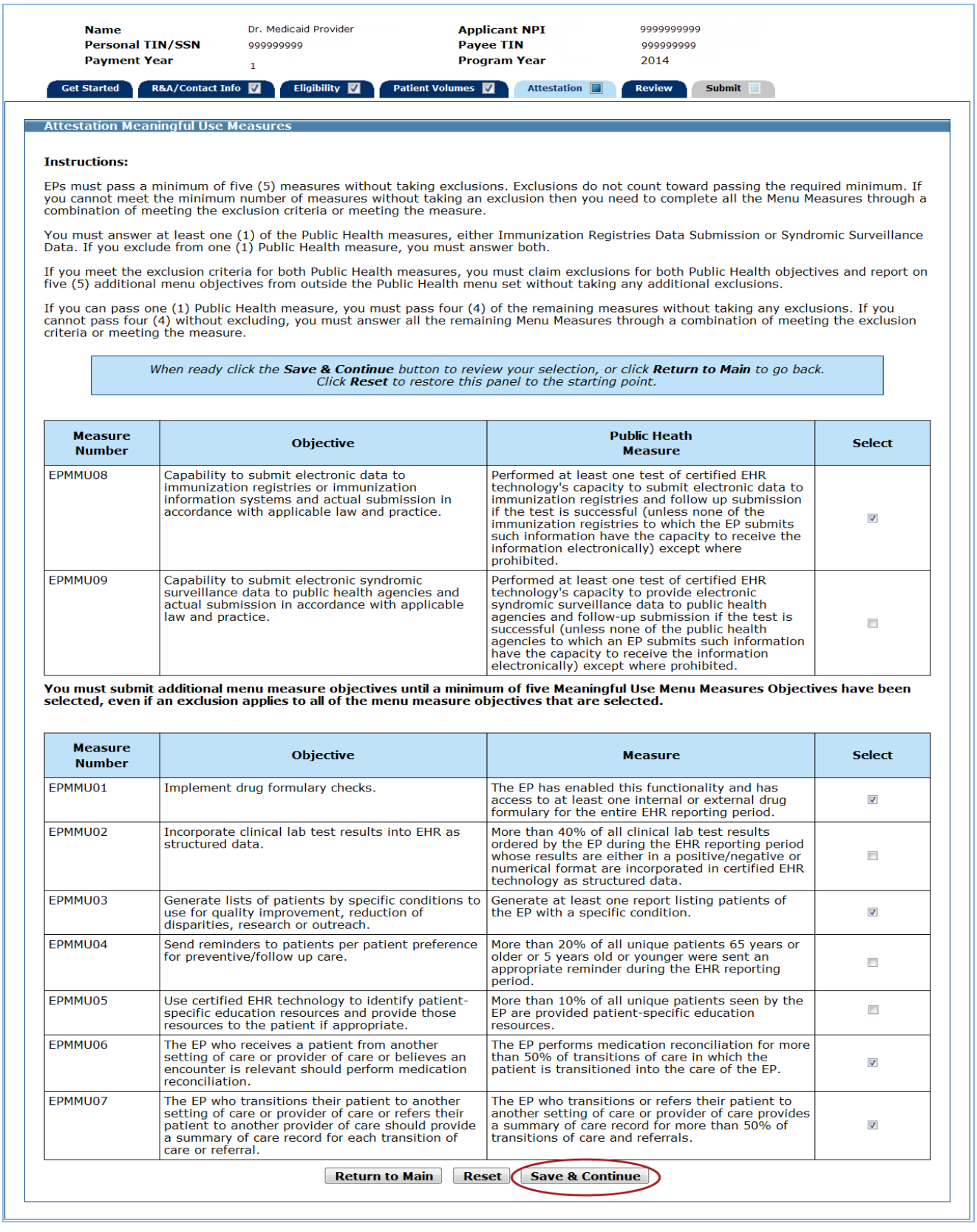
MEANINGFUL USE MENU SET MEASURES (Stage 1)
As part of the meaningful use attestation process, Eligible Professionals (EPs) are required to complete 5 out of 9 Menu Set Measures in Stage 1 (5 out of 10 Menu Set Measures for 2013 MU Stage 1).
HELPFUL HINTS
1. The Menu Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 10%, a result of 10.1% will pass but a result of exactly 10.0% would not pass.
6. After completing the required number of menu measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Begin

From the Meaningful Use Menu Measures Selection screen displayed on the following page, choose a minimum of five Meaningful Use Menu Measures to attest to. One measure must be from the public health list (first two measures listed on the top half of the screen). The remainder of the measures can be any combination from the remaining public health list measures or from the additional Meaningful Use Menu Measures listed. In the example shown on the following page, one public health measure and four measures from the additional Meaningful Use Measures listed are selected.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.



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Attestation Meaningful Use Measures

Instructions:

EPs must pass a minimum of five (5) measures without taking exclusions. Exclusions do not count toward passing the required minimum. If you cannot meet the minimum number of measures without taking an exclusion then you need to complete all the Menu Measures through a combination of meeting the exclusion criteria or meeting the measure.

You must answer at least one (1) of the Public Health measures, either Immunization Registries Data Submission or Syndromic Surveillance Data. If you exclude from one (1) Public Health measure, you must answer both.

If you meet the exclusion criteria for both Public Health measures, you must claim exclusions for both Public Health objectives and report on five (5) additional menu objectives from outside the Public Health menu set without taking any additional exclusions.

If you can pass one (1) Public Health measure, you must pass four (4) of the remaining measures without taking any exclusions. If you cannot pass four (4) without excluding, you must answer all the remaining Menu Measures through a combination of meeting the exclusion criteria or meeting the measure.

*When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Measure Number	Objective	Public Heath Measure	Select
EPMMU08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) except where prohibited.	☑
EPMMU09	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically) except where prohibited.	☐

You must submit additional menu measure objectives until a minimum of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected.

Measure Number	Objective	Measure	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
EPMMU02	Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☐
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	☑
EPMMU04	Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	☐
EPMMU05	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	☐
EPMMU06	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	☑
EPMMU07	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☑

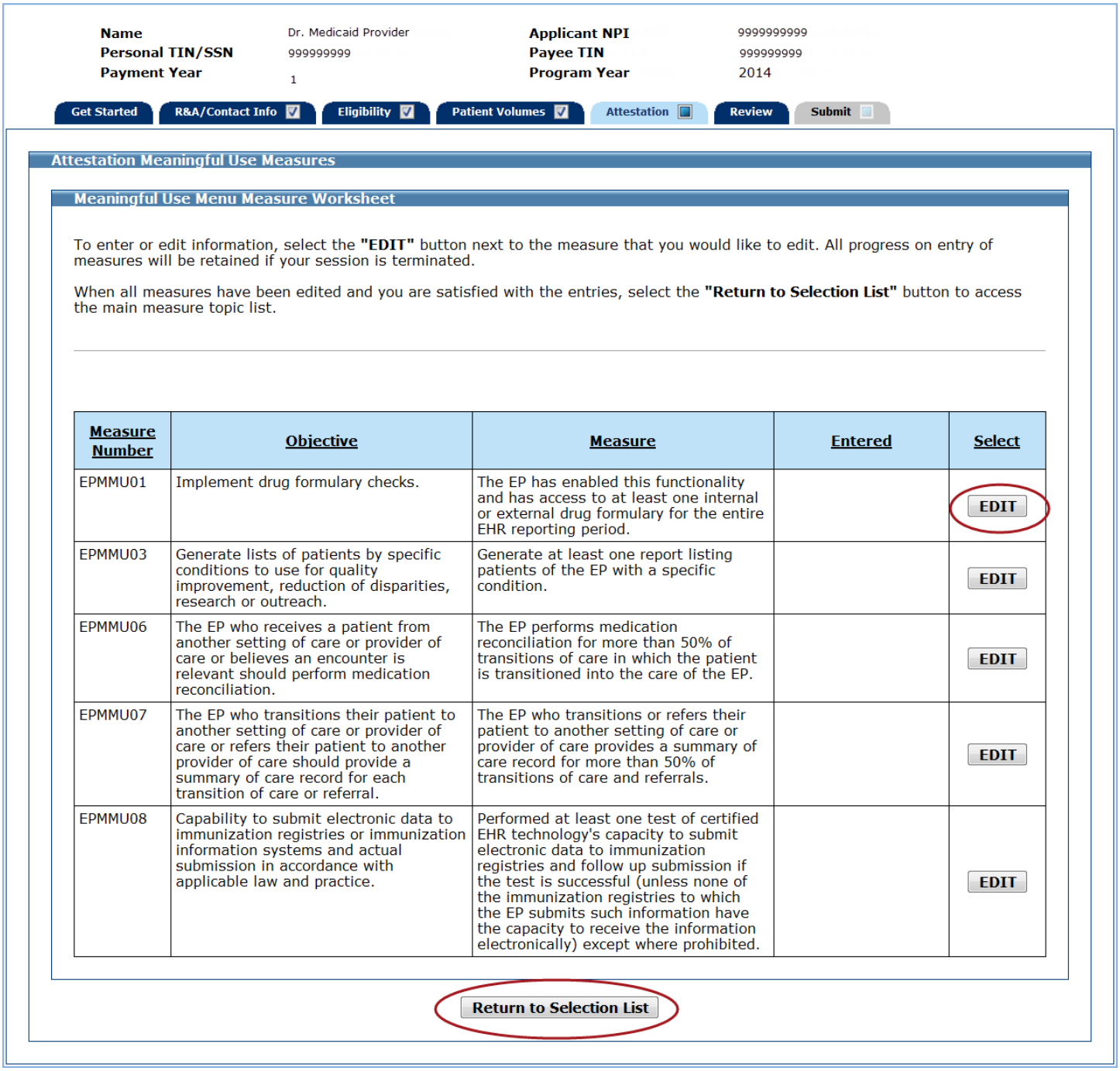
Return to Main | Reset | Save & Continue

The five measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the five measures selected on the previous screen example.

You must complete all the measures on this screen.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure, or click **Return to Selection List** to return to the Meaningful Use Menu Measures Selection screen.



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Payment Year 1 **Program Year** 2014

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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.		EDIT
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.		EDIT
EPMMU06	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.		EDIT
EPMMU07	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.		EDIT
EPMMU08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) except where prohibited.		EDIT

Return to Selection List

The following is a list of the Meaningful Use Menu Measures that you may attest to.

Click on the Screen Example to see an example of the screen layout.

Meaningful Use Menu Measure	Screen Example
Menu Measure 1 – Drug Formulary Checks	Screen 1
Menu Measure 2 – Clinical Lab Test Results	Screen 2
Menu Measure 3 – Patient List	Screen 3
Menu Measure 4 – Patient Reminders	Screen 4
Menu Measure 5 – Patient-Specific Education Resources	Screen 5
Menu Measure 6 – Medication Reconciliation	Screen 4
Menu Measure 7 – Transition of Care Summary	Screen 4
Menu Measure 8 – Immunization Registries Data Submission	Screen 6
Menu Measure 9 – Syndromic Surveillance Data	Screen 6

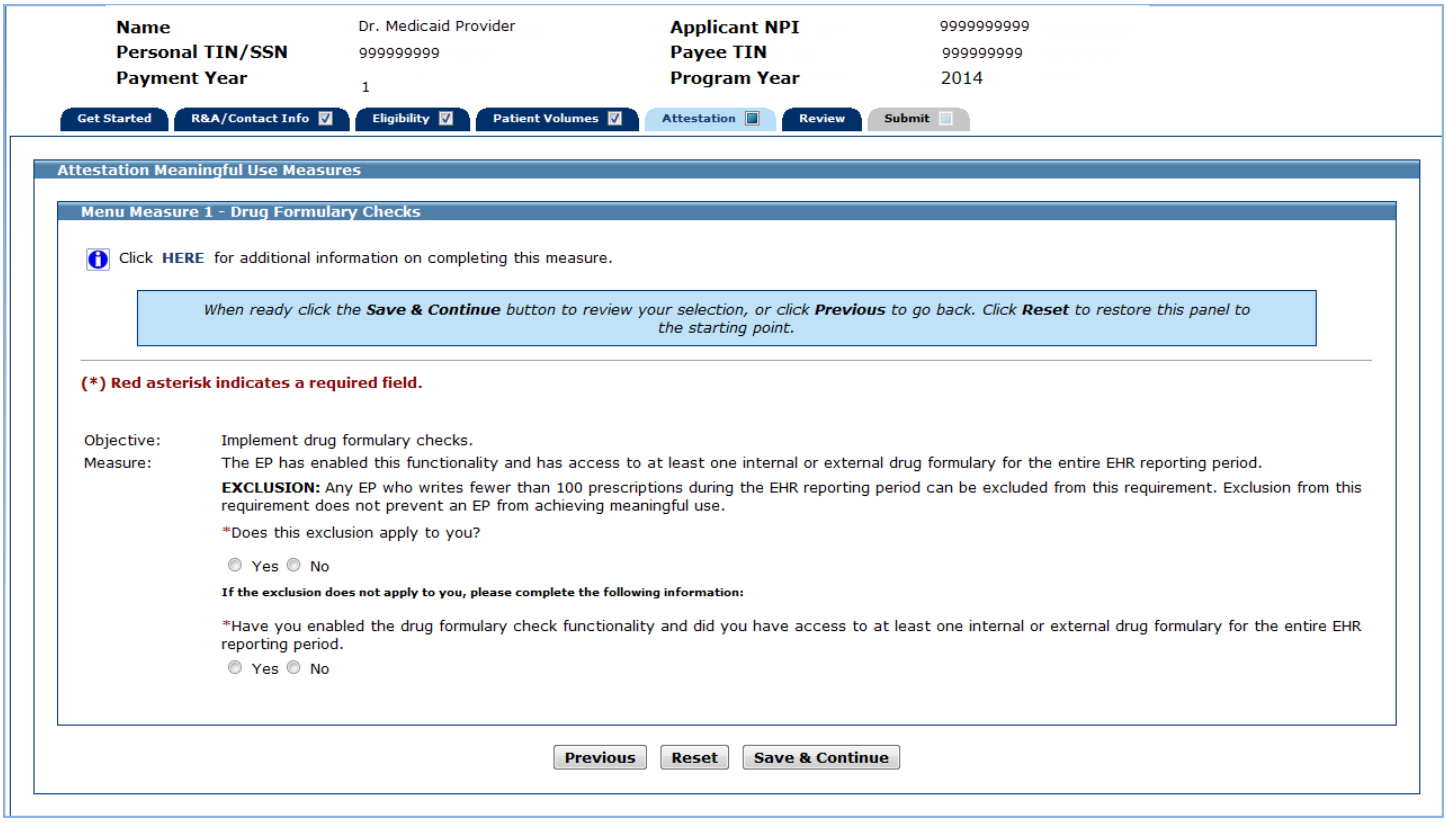
There are a total of 9 Meaningful Use Menu Measure screens. As you proceed through the Meaningful Use Menu Measure section of MAPIR, you will see six different screen layouts. Instructions for each measure are provided on the screen. For additional help with a specific Meaningful Use Menu Measure, click on the link provided above the blue instruction box.

Screen layout examples are shown below.

Screen 1

The following Meaningful Use Menu Measures use this screen layout:

Menu Measure 1


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
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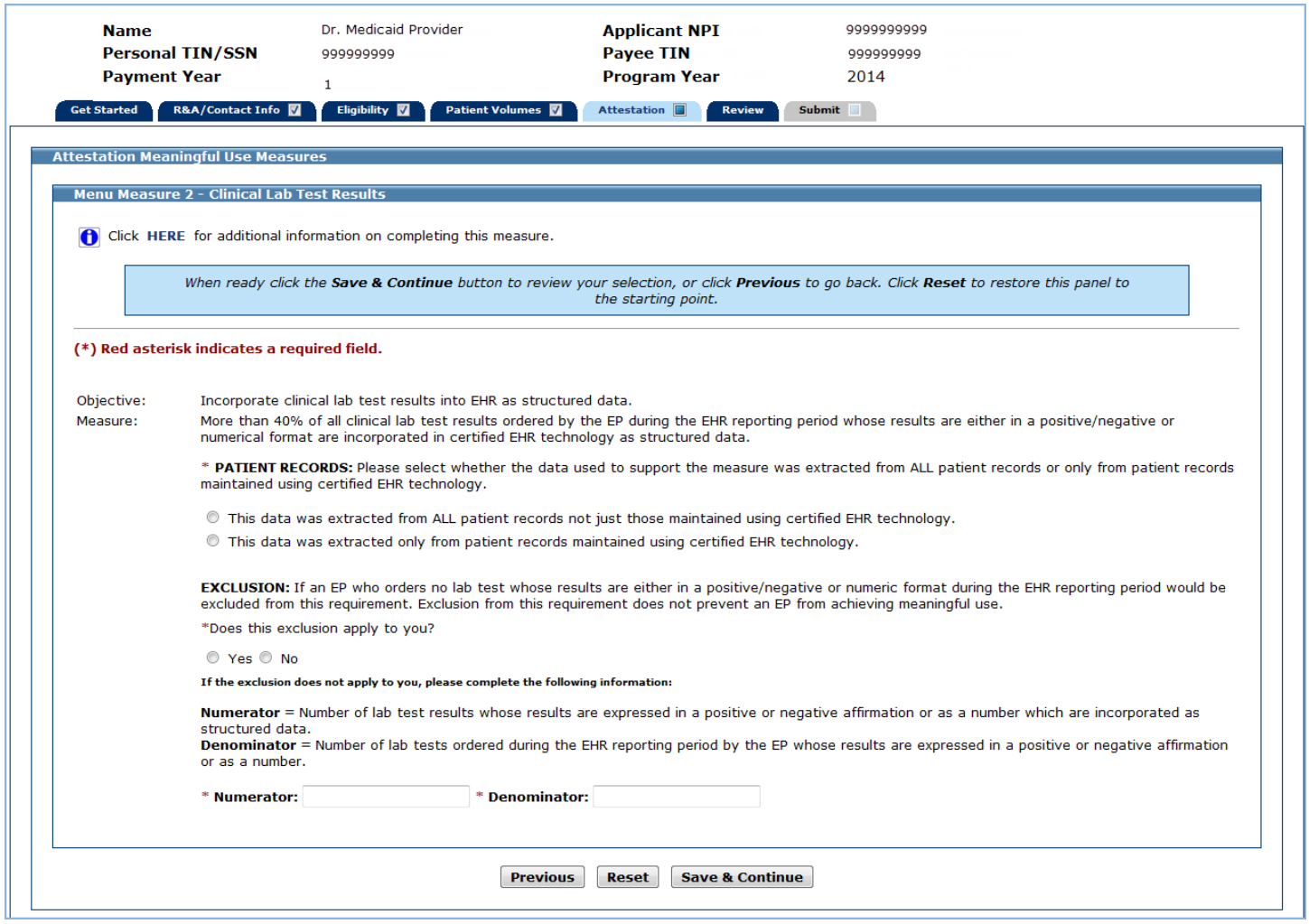
Attestation Meaningful Use Measures
Menu Measure 1 - Drug Formulary Checks
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Implement drug formulary checks.
Measure:
The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
EXCLUSION: Any EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
If the exclusion does not apply to you, please complete the following information:
*Have you enabled the drug formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period.
Yes No
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Menu Measures use this screen layout:

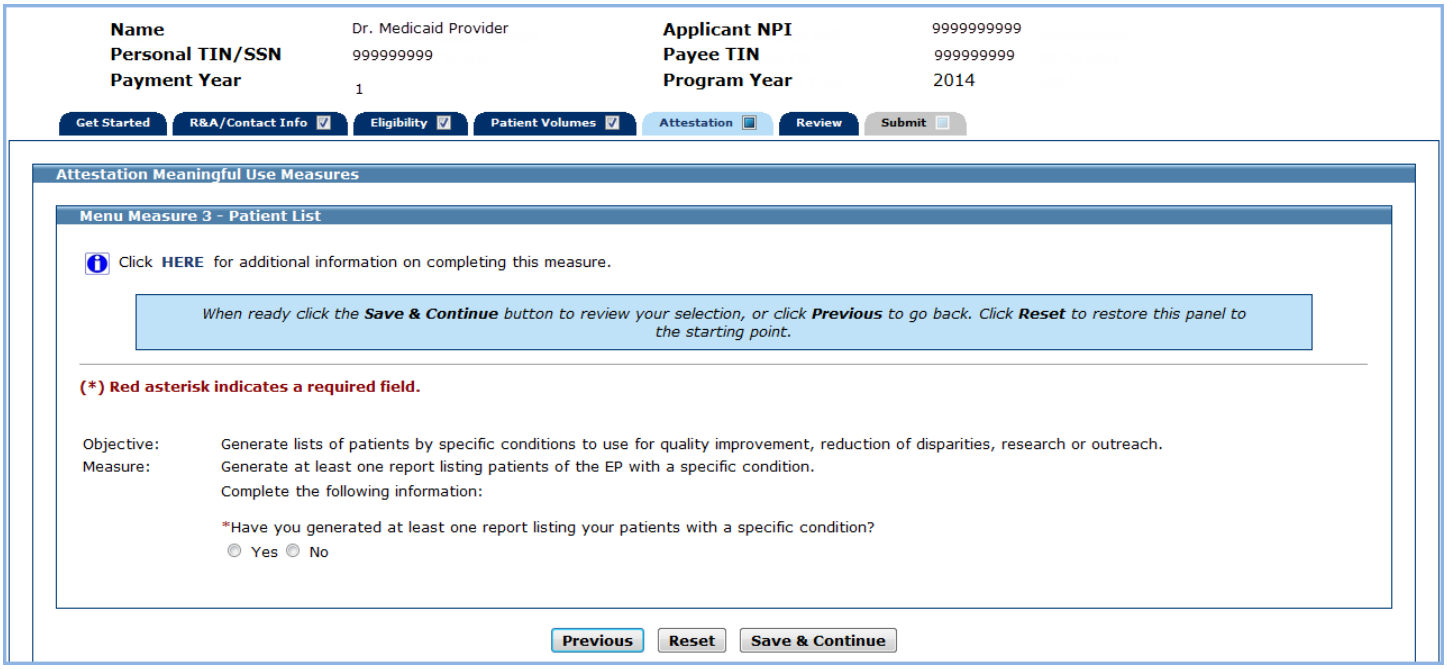
Menu Measure 2


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 2 - Clinical Lab Test Results
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Incorporate clinical lab test results into EHR as structured data.
Measure:
More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION: If an EP who orders no lab test whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply to you, please complete the following information:
Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Denominator = Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 3

The following Meaningful Use Menu Measures use this screen layout:

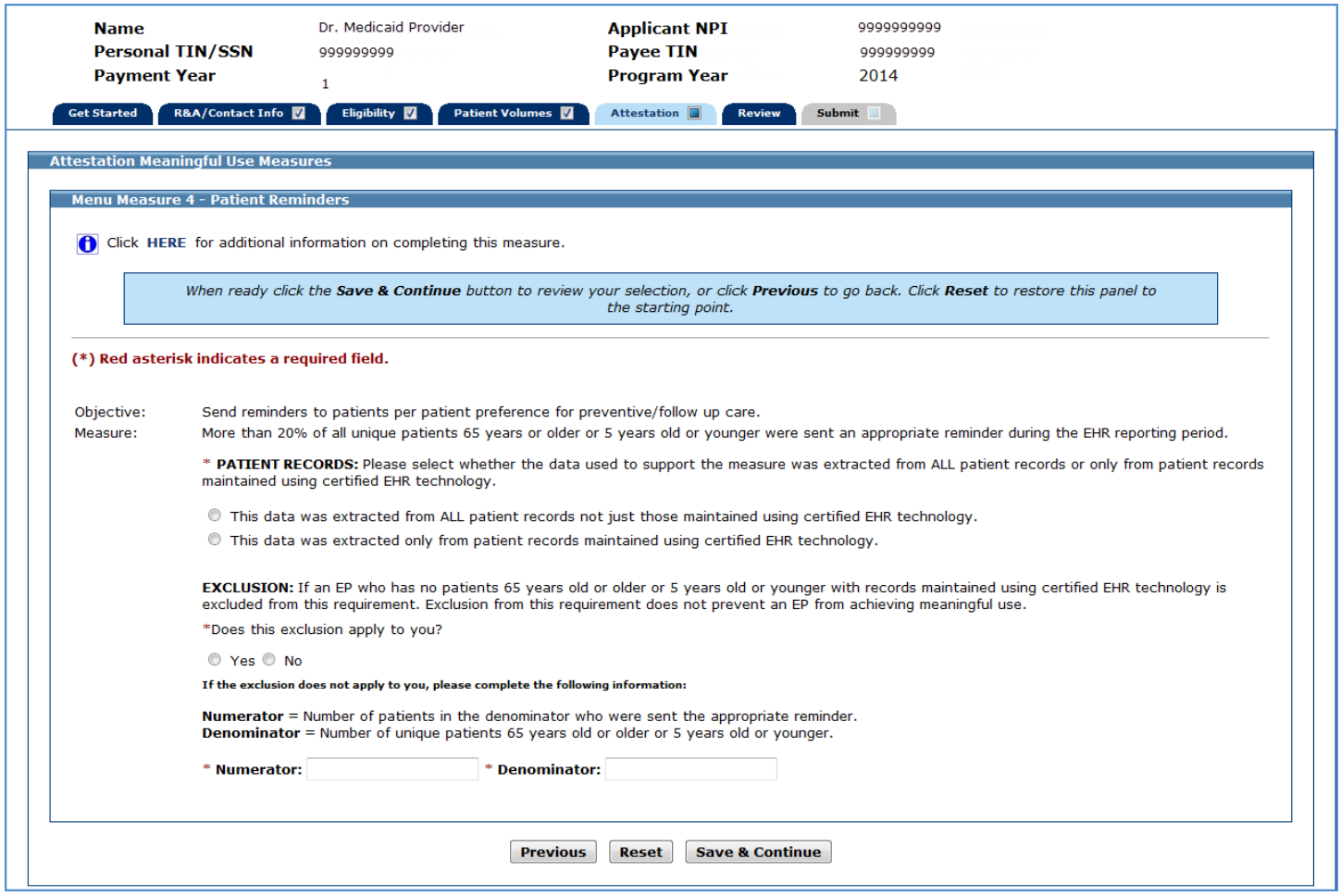
Menu Measure 3


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 3 - Patient List
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.
Measure:
Generate at least one report listing patients of the EP with a specific condition.
Complete the following information:
*Have you generated at least one report listing your patients with a specific condition?
Yes
No
Previous
Reset
Save & Continue

Screen 4

The following Meaningful Use Menu Measures use this screen layout:

Menu Measures 4, 6, and 7


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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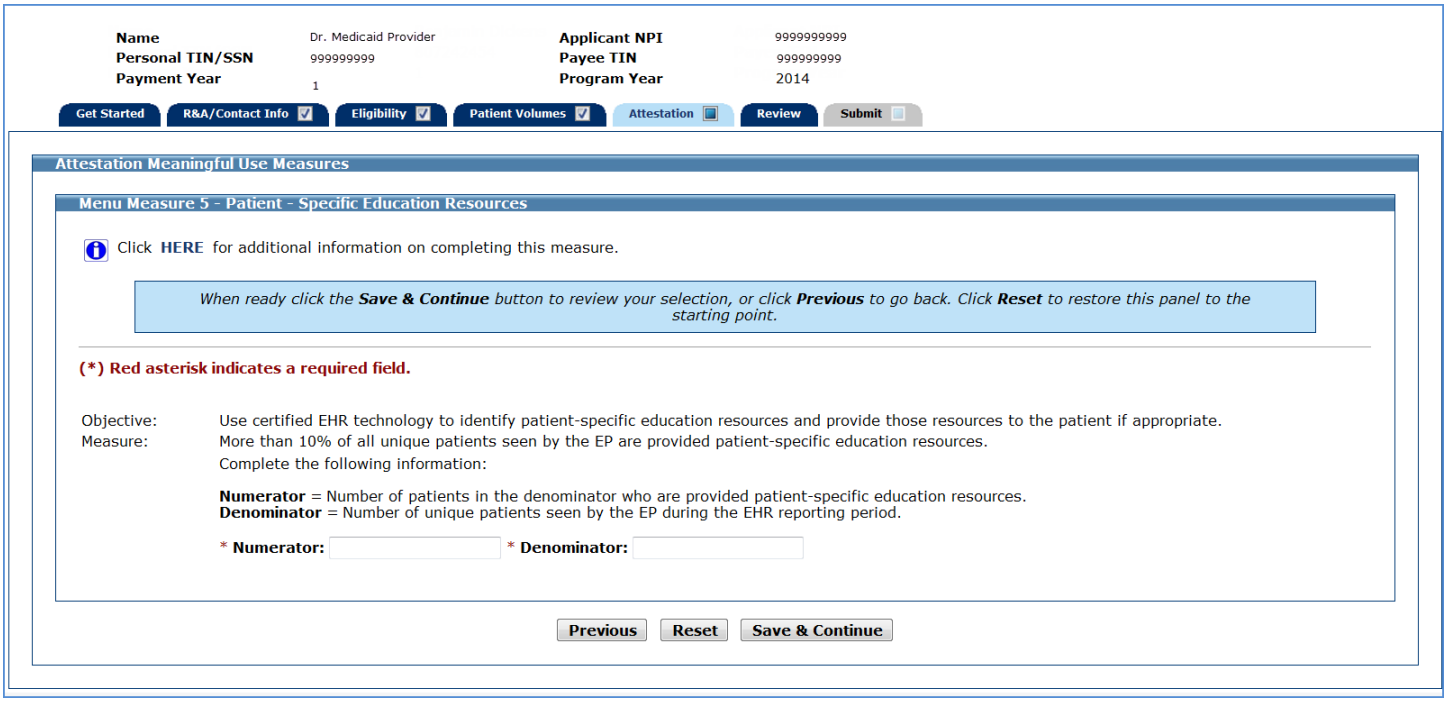
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 4 - Patient Reminders
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Send reminders to patients per patient preference for preventive/follow up care.
Measure:
More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION: If an EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply to you, please complete the following information:
Numerator = Number of patients in the denominator who were sent the appropriate reminder.
Denominator = Number of unique patients 65 years old or older or 5 years old or younger.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 5

The following Meaningful Use Menu Measures use this screen layout:

Menu Measure 5


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
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Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 5 - Patient - Specific Education Resources
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure:
More than 10% of all unique patients seen by the EP are provided patient-specific education resources.
Complete the following information:
Numerator = Number of patients in the denominator who are provided patient-specific education resources.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 6

The following Meaningful Use Menu Measures use this screen layout:

Menu Measures 8 and 9

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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Payee TIN
999999999
Payment Year
1
Program Year
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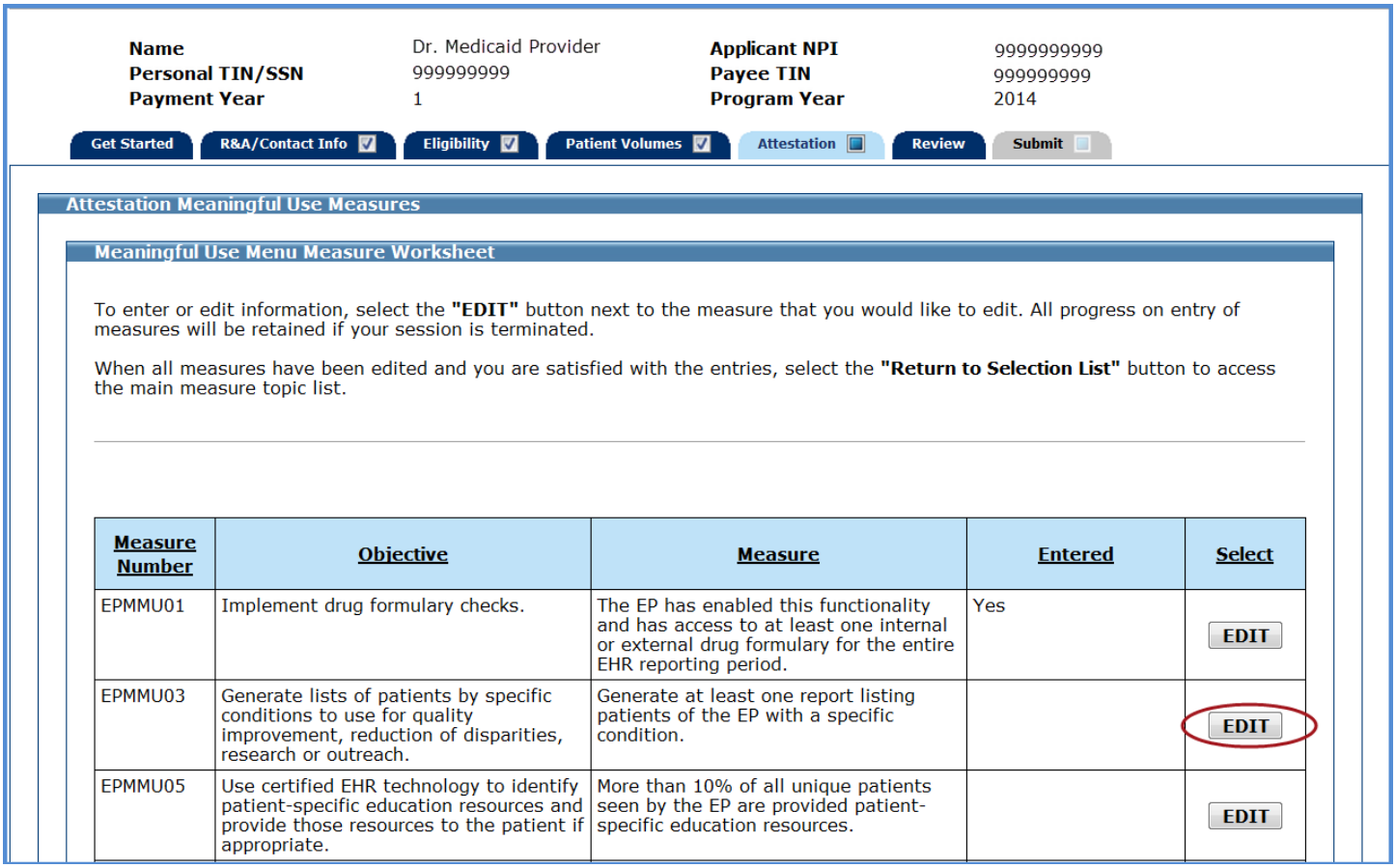
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 8 - Immunization Registries Data Submission
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) except where prohibited.
EXCLUSION 1: An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
EXCLUSION 2: If there is no immunization registry that has the capacity to receive the information electronically or if it is prohibited, an EP would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
Note: If you would like to upload additional information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab.
If the exclusions do not apply to you, please answer the following question:
*Did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)?
Yes No
Additional Information:
* Enter the name of the immunization registry used:
If you performed at least one test of EHR submission of electronic data to immunization registries:
Was the test successful?
Yes
No
If the test was successful, please enter the date and time of the test:
Date (MM/DD/YYYY)
Time (HH:MM AM/PM) (Example: 09:15 PM)
If you answered Yes to 'Was the test successful', you must answer the following:
Was a follow up submission done? Yes No
Previous
Reset
Save & Continue

After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click **Edit** for the next measure.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
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Attestation Meaningful Use Measures

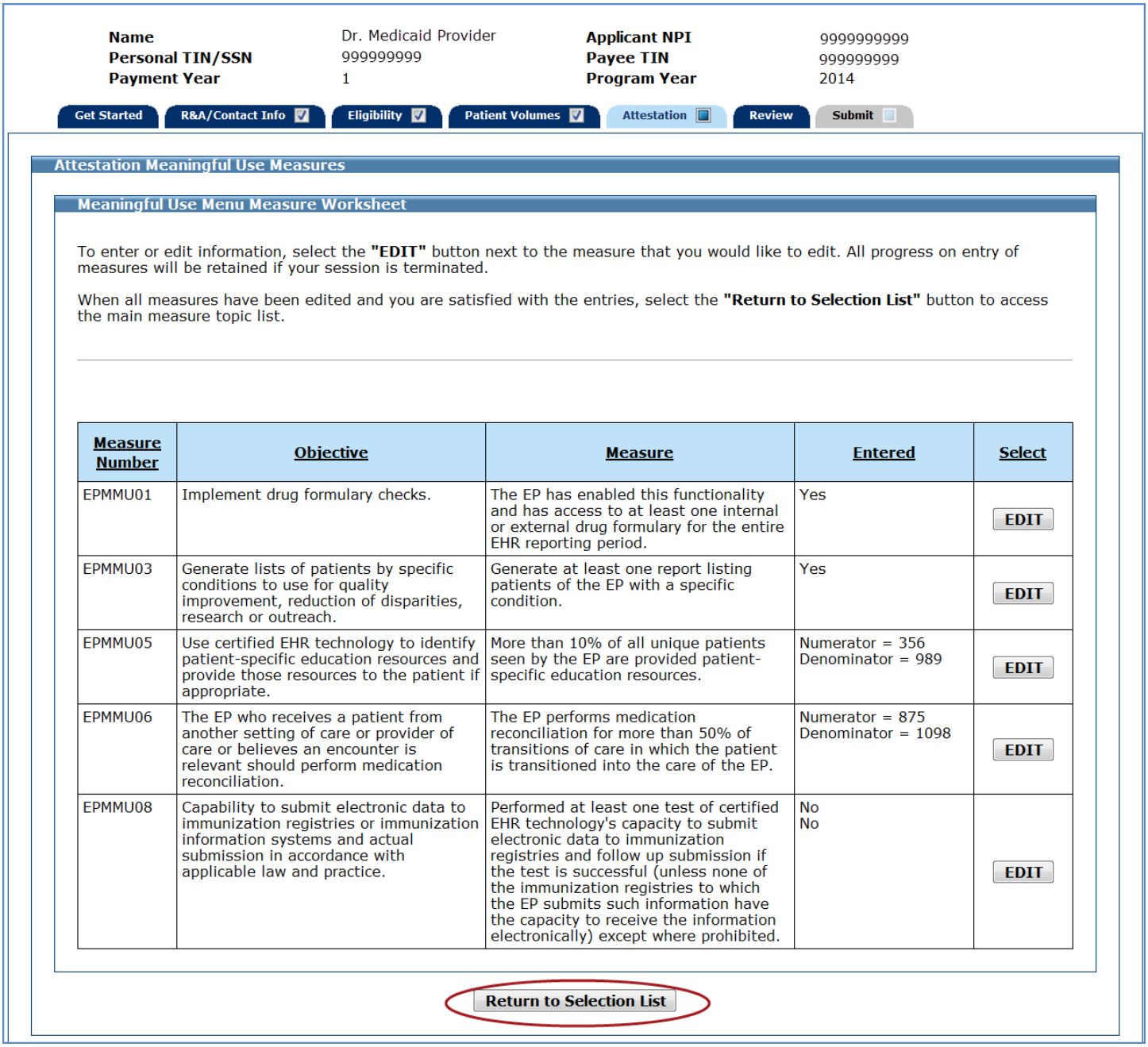
Meaningful Use Menu Measure Worksheet

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	EDIT
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.		EDIT
EPMMU05	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.		EDIT

Once you have attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Menu Measure Selection screen.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

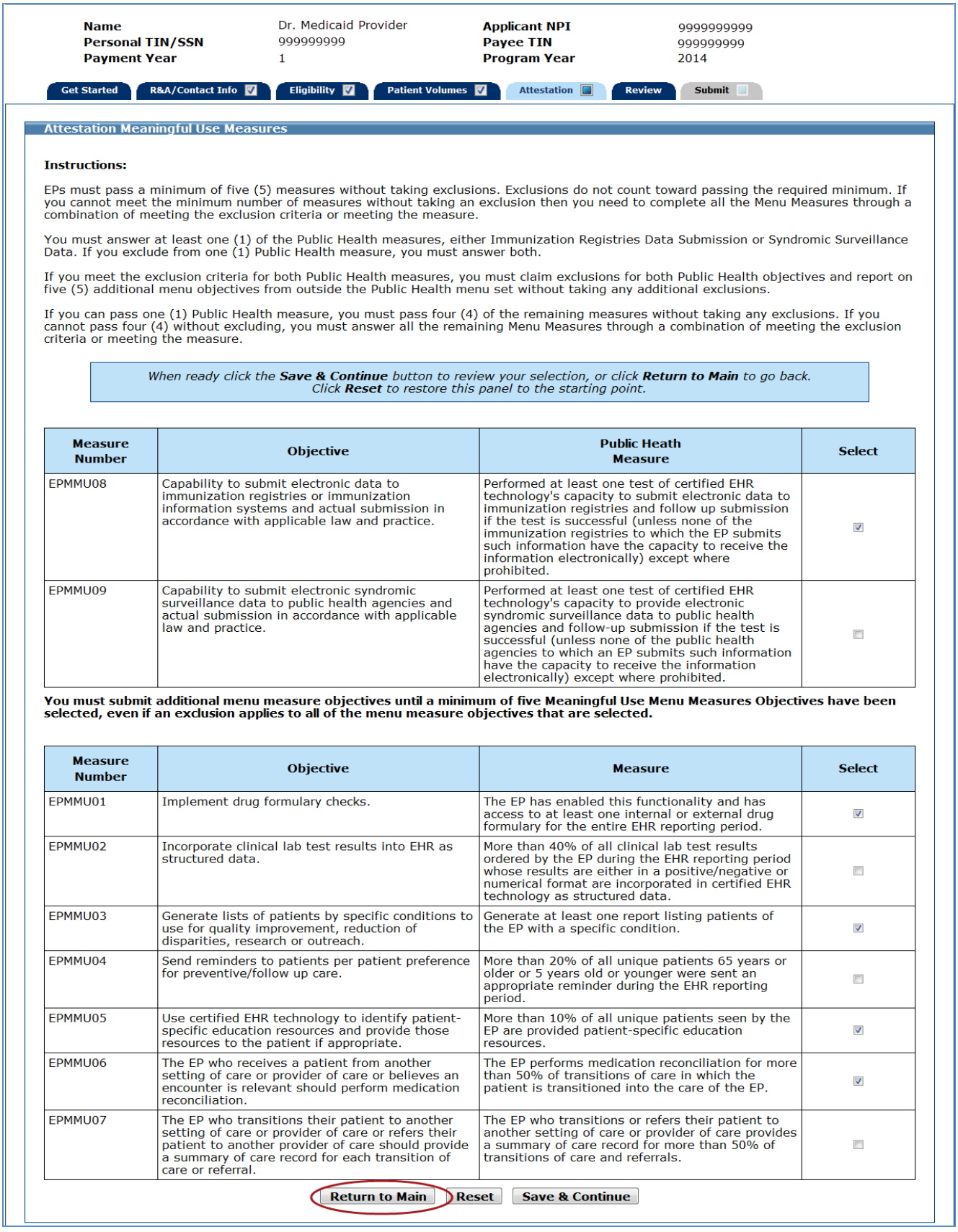
To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	EDIT
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes	EDIT
EPMMU05	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	Numerator = 356 Denominator = 989	EDIT
EPMMU06	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	Numerator = 875 Denominator = 1098	EDIT
EPMMU08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) except where prohibited.	No No	EDIT

Return to Selection List

Click **Return to Main** to return to the Measure Topic List.



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Attestation Meaningful Use Measures

Instructions:

EPs must pass a minimum of five (5) measures without taking exclusions. Exclusions do not count toward passing the required minimum. If you cannot meet the minimum number of measures without taking an exclusion then you need to complete all the Menu Measures through a combination of meeting the exclusion criteria or meeting the measure.

You must answer at least one (1) of the Public Health measures, either Immunization Registries Data Submission or Syndromic Surveillance Data. If you exclude from one (1) Public Health measure, you must answer both.

If you meet the exclusion criteria for both Public Health measures, you must claim exclusions for both Public Health objectives and report on five (5) additional menu objectives from outside the Public Health menu set without taking any additional exclusions.

If you can pass one (1) Public Health measure, you must pass four (4) of the remaining measures without taking any exclusions. If you cannot pass four (4) without excluding, you must answer all the remaining Menu Measures through a combination of meeting the exclusion criteria or meeting the measure.

*When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Measure Number	Objective	Public Heath Measure	Select
EPMMU08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) except where prohibited.	☑
EPMMU09	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically) except where prohibited.	☐

You must submit additional menu measure objectives until a minimum of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected.

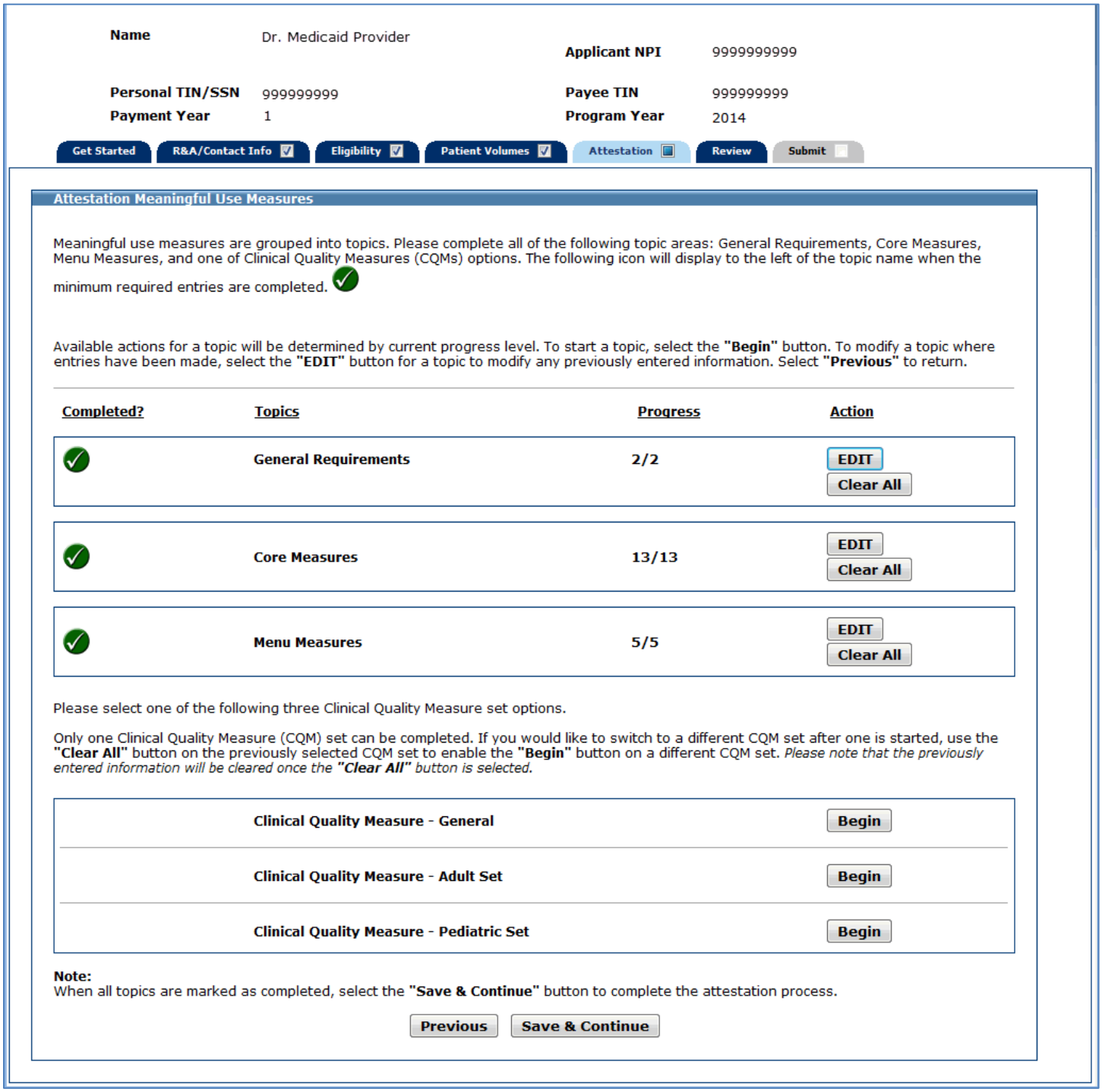
Measure Number	Objective	Measure	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
EPMMU02	Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☐
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	☑
EPMMU04	Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	☐
EPMMU05	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	☑
EPMMU06	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	☑
EPMMU07	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☐

Return to Main | Reset | Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, or click **Clear All** to clear the topic information you entered. Click **Begin** to start the next topic.

Proceed to the Meaningful Use Clinical Quality Measures (Stage 1 and Stage 2) section on page 152.



Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999

Payee TIN 999999999

Payment Year 1

Program Year 2014

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Attestation Meaningful Use Measures

Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.

Available actions for a topic will be determined by current progress level. To start a topic, select the **"Begin"** button. To modify a topic where entries have been made, select the **"EDIT"** button for a topic to modify any previously entered information. Select **"Previous"** to return.

Completed?	Topics	Progress	Action
✓	General Requirements	2/2	EDIT Clear All
✓	Core Measures	13/13	EDIT Clear All
✓	Menu Measures	5/5	EDIT Clear All

Please select one of the following three Clinical Quality Measure set options.

Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the **"Clear All"** button on the previously selected CQM set to enable the **"Begin"** button on a different CQM set. *Please note that the previously entered information will be cleared once the **"Clear All"** button is selected.*

Clinical Quality Measure - General	Begin
Clinical Quality Measure - Adult Set	Begin
Clinical Quality Measure - Pediatric Set	Begin

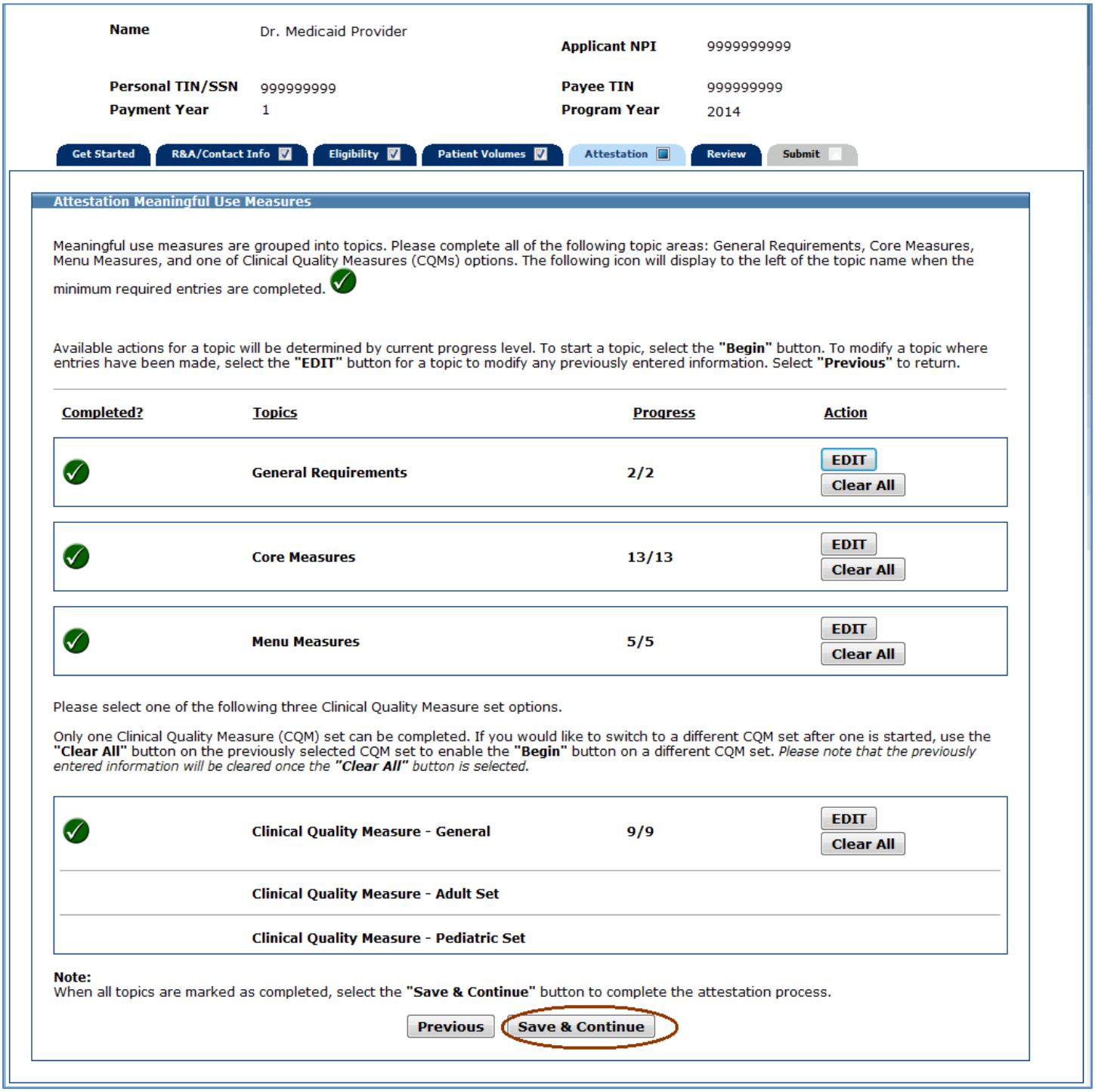
Note:
When all topics are marked as completed, select the **"Save & Continue"** button to complete the attestation process.

Previous Save & Continue

Meaningful Use Measures Summary for Stage 1

This screen displays the Measures Topic List for **Stage 1** with all three Meaningful Use Measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.

Proceed to the Meaningful Use Measures Summary screen the following page.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
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Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
13/13
EDIT
Clear All
Menu Measures
5/5
EDIT
Clear All
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
9/9
EDIT
Clear All
Clinical Quality Measure - Adult Set
Clinical Quality Measure - Pediatric Set
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click **Previous** to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click **Save & Continue** to proceed to Part 3 of 3 of the Attestation Phase.

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Attestation Meaningful Use Measures

The Meaningful Use Measures you have attested to are depicted below. Please review the current information to verify what you have entered is correct.

Meaningful Use General Requirements Review

Question	Entered
Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.	Numerator = 1 Denominator = 1 Percentage = 100%
Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.	Numerator = 1 Denominator = 1 Percentage = 100%
<Enter Professional General Tips 1>	Yes
<Enter Professional General Tips 2>	Yes
<Enter Professional General Tips 3>	Yes

Meaningful Use Core Measure Review

Measure Code	Title	Entered	Additional Information
EPCMU01	Core Measure 1 - CPOE for Medication Orders Original	Numerator = 350 Denominator = 1001 Percentage = 34%	Patient Records = All
EPCMU02	Core Measure 2 - Drug Interaction Checks	Yes	N/A
EPCMU03	Core Measure 3 - Maintain Problem List	Numerator = 1 Denominator = 1 Percentage = 100%	N/A
EPCMU04	Core Measure 4 - ePrescribing (eRx)	Exclusion 1 = No Exclusion 2 = No Numerator = 1 Denominator = 1 Percentage = 100%	N/A
EPCMU05	Core Measure 5 - Active Medication List	Numerator = 1 Denominator = 1 Percentage = 100%	N/A
EPCMU06	Core Measure 6 - Medication Allergy List	Numerator = 1 Denominator = 1 Percentage = 100%	N/A

This is screen 2 of 4 of the Meaningful Use Measure Review.

EPCMU07	Core Measure 7 - Record Demographics	Numerator = 1 Denominator = 1 Percentage = 100%	N/A
EPCMU08	Core Measure 8 - Record Vital Signs	Exclusion 1 = No Exclusion 2 = No Exclusion 3 = No Exclusion 4 = No Numerator = 1 Denominator = 1 Percentage = 100%	Patient Records = All
EPCMU09	Core Measure 9 - Record Smoking Status	Numerator = 1 Denominator = 1 Percentage = 100%	Patient Records = All
EPCMU10	Core Measure 10 - Clinical Decision Support Rule	Yes	N/A
EPCMU11	Core Measure 11 - Patient Electronic Access	Numerator = 1 Denominator = 1 Percentage = 100%	N/A
EPCMU12	Core Measure 12 - Clinical Summaries	Numerator = 1 Denominator = 1 Percentage = 100%	Patient Records = All
EPCMU13	Core Measure 13 - Protect Electronic Health Information	Yes	N/A

Meaningful Use Menu Measure Review

Measure Code	Title	Entered	Additional Information
EPMMU01	Menu Measure 1 - Drug Formulary Checks	Yes	N/A
EPMMU03	Menu Measure 3 - Patient List	Yes	N/A
EPMMU05	Menu Measure 5 - Patient - Specific Education Resources	Numerator = 356 Denominator = 989 Percentage = 35%	N/A
EPMMU06	Menu Measure 6 - Medication Reconciliation	Numerator = 875 Denominator = 1098 Percentage = 79%	N/A
EPMMU08	Menu Measure 8 - Immunization Registries Data Submission	No No	See below for additional information

Additional Information

EPMMU08

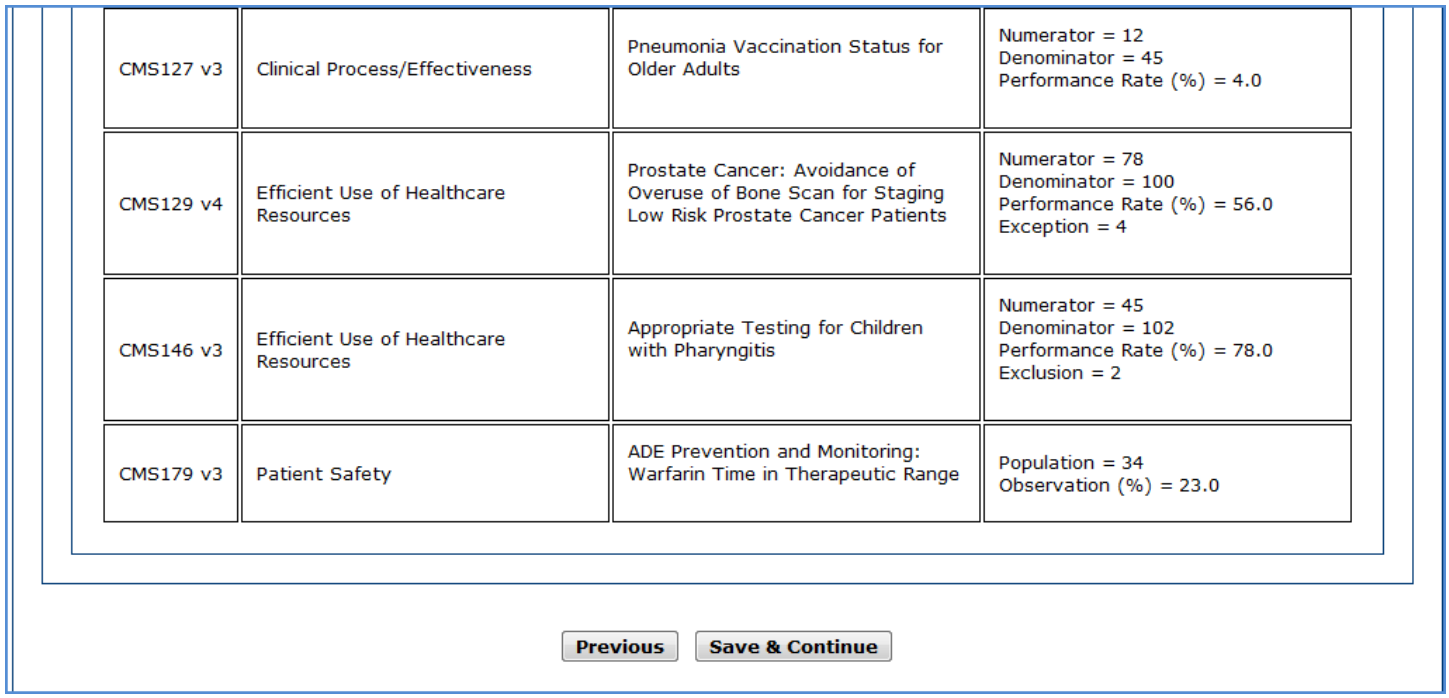
Immunization Registry : Immunization Reg
Test Successful : Yes
Test Date & Time : 10/23/2013 09:20 PM
Follow Up Submission : Yes

This is screen 3 of 4 of the Meaningful Use Measure Review.

Meaningful Use Clinical Quality Measure Review

Measure Code	Domain	Title	Entered
CMS50 v3	Care Coordination	Closing the referral loop: receipt of specialist report	Numerator = 25 Denominator = 100 Performance Rate (%) = 10.0
CMS52 v3	Clinical Process/Effectiveness	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Stratum 1 Numerator 1 = 34 Denominator 1 = 100 Performance Rate 1 (%) = 13.0 Exception 1 = 3 Stratum 2 Numerator 2 = 45 Denominator 2 = 123 Performance Rate 2 (%) = 12.0 Exception 2 = 5 Stratum 3 Numerator 3 = 45 Denominator 3 = 100 Performance Rate 3 (%) = 4.0
CMS61 v4	Clinical Process/Effectiveness	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Stratum 1 Numerator 1 = 23 Denominator 1 = 102 Performance Rate 1 (%) = 2.0 Exclusion 1 = 4 Exception 1 = 12 Stratum 2 Numerator 2 = 34 Denominator 2 = 105 Performance Rate 2 (%) = 3.0 Exclusion 2 = 5 Exception 2 = 12 Stratum 3 Numerator 3 = 54 Denominator 3 = 100 Performance Rate 3 (%) = 10.0 Exclusion 3 = 7 Exception 3 = 14
CMS125 v3	Clinical Process/Effectiveness	Breast Cancer Screening	Numerator = 23 Denominator = 101 Performance Rate (%) = 4.0 Exclusion = 5
CMS126 v3	Clinical Process/Effectiveness	Use of Appropriate Medications for Asthma	Stratum 1 Numerator 1 = 12 Denominator 1 = 67 Performance Rate 1 (%) = 3.0 Exclusion 1 = 5 Stratum 2 Numerator 2 = 34 Denominator 2 = 120 Performance Rate 2 (%) = 12.0 Exclusion 2 = 7 Stratum 3 Numerator 3 = 23 Denominator 3 = 100 Performance Rate 3 (%) = 15.0 Exclusion 3 = 12 Stratum 4 Numerator 4 = 32 Denominator 4 = 123 Performance Rate 4 (%) = 20.0 Exclusion 4 = 15 Stratum 5 Numerator 5 = 24 Denominator 5 = 156 Performance Rate 5 (%) = 35.0 Exclusion 5 = 4

This is screen 4 of 4 of the Meaningful Use Measure Review.



CMS127 v3	Clinical Process/Effectiveness	Pneumonia Vaccination Status for Older Adults	Numerator = 12 Denominator = 45 Performance Rate (%) = 4.0
CMS129 v4	Efficient Use of Healthcare Resources	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Numerator = 78 Denominator = 100 Performance Rate (%) = 56.0 Exception = 4
CMS146 v3	Efficient Use of Healthcare Resources	Appropriate Testing for Children with Pharyngitis	Numerator = 45 Denominator = 102 Performance Rate (%) = 78.0 Exclusion = 2
CMS179 v3	Patient Safety	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Population = 34 Observation (%) = 23.0

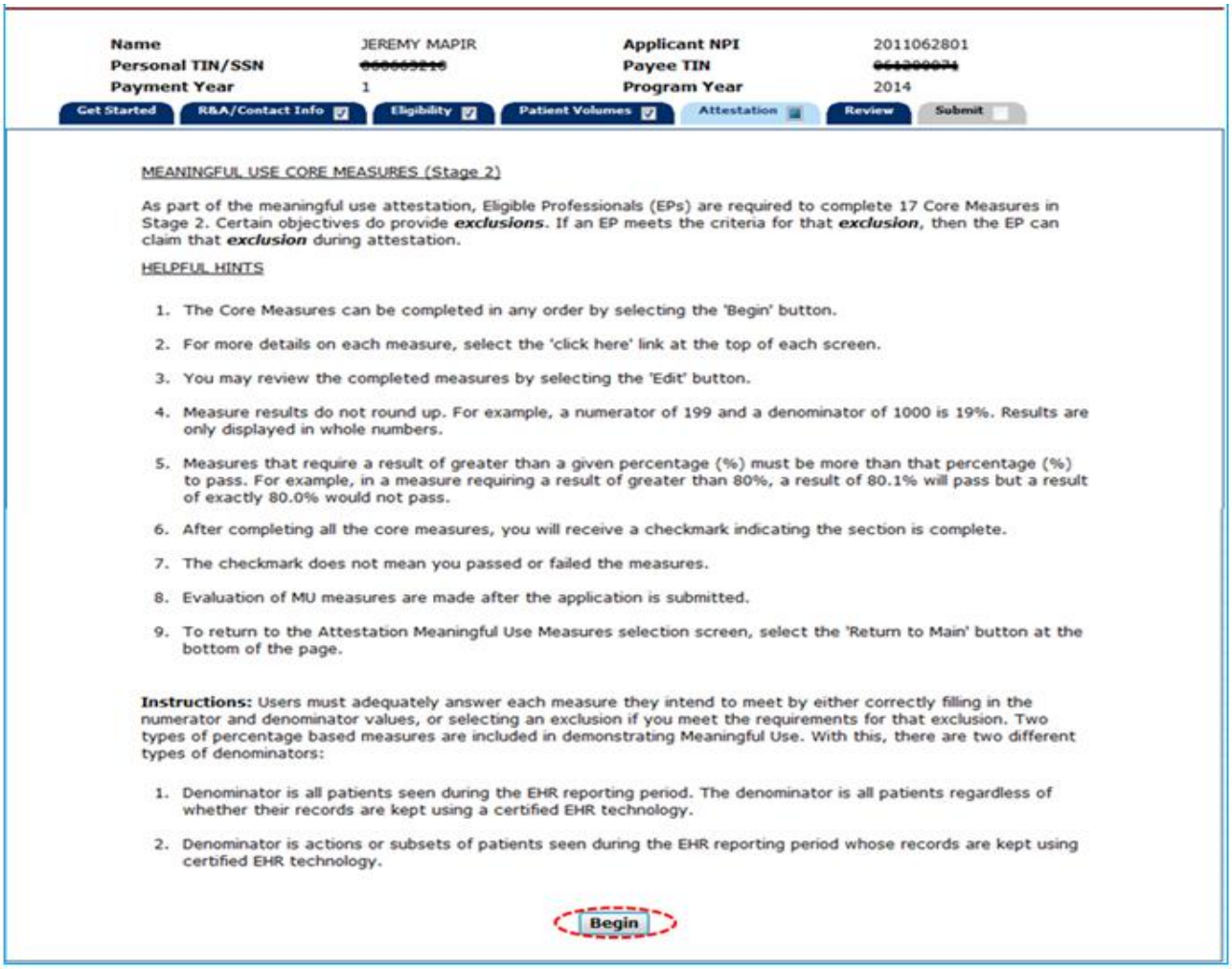
Proceed to the Attestation Phase (Part 3 of 3) on page 171.

Stage 2

Meaningful Use Core Measures

This screen provides information about the Meaningful Use Core Measures for Stage 2.

Click **Begin** to continue to the Meaningful Use Core Measure List Table.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
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MEANINGFUL USE CORE MEASURES (Stage 2)
As part of the meaningful use attestation, Eligible Professionals (EPs) are required to complete 17 Core Measures in Stage 2. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation.
HELPFUL HINTS
1. The Core Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.1% will pass but a result of exactly 80.0% would not pass.
6. After completing all the core measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Instructions: Users must adequately answer each measure they intend to meet by either correctly filling in the numerator and denominator values, or selecting an exclusion if you meet the requirements for that exclusion. Two types of percentage based measures are included in demonstrating Meaningful Use. With this, there are two different types of denominators:
1. Denominator is all patients seen during the EHR reporting period. The denominator is all patients regardless of whether their records are kept using a certified EHR technology.
2. Denominator is actions or subsets of patients seen during the EHR reporting period whose records are kept using certified EHR technology.
Begin

The screens on the following two pages display the Meaningful Use Core Measure List Table.

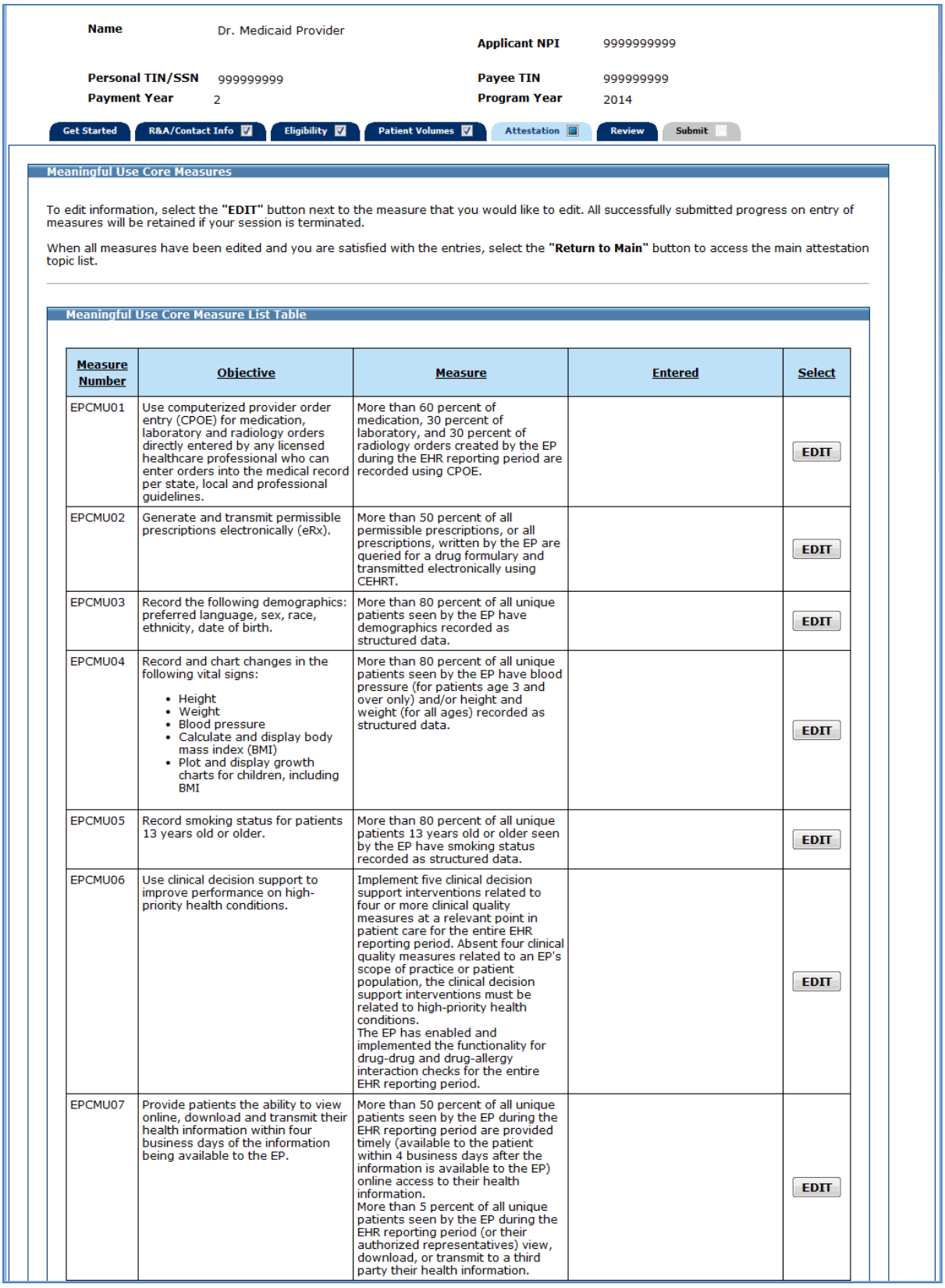
You must attest to all 17 Meaningful Use Core Measures.

The first time a topic is accessed you will see an **Edit** option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return to Main** to return to the Measures Topic List.

This is screen 1 of 2 of the Meaningful Use Core Measure List Table.



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Payee TIN 999999999
Payment Year 2
Program Year 2014

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Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.		EDIT
EPCMU02	Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.		EDIT
EPCMU03	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.		EDIT
EPCMU04	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children, including BMI	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.		EDIT
EPCMU05	Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.		EDIT
EPCMU06	Use clinical decision support to improve performance on high-priority health conditions.	Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		EDIT
EPCMU07	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.		EDIT

This is screen 2 of 2 of the Meaningful Use Core Measure List Table.

EPCMU08	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.		EDIT
EPCMU09	Protect electronic health information created or maintained by the Certified EHR Technology (CEHRT) through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.		EDIT
EPCMU10	Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.	More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.		EDIT
EPCMU11	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.		EDIT
EPCMU12	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.	More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.		EDIT
EPCMU13	Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.		EDIT
EPCMU14	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.		EDIT
EPCMU15	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. An EP must satisfy one of the following criteria: (a) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). (b) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.		EDIT
EPCMU16	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.		EDIT
EPCMU17	Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.		EDIT

Return to Main

The following is a list of the 17 Meaningful Use Core Measures that you must attest to.

Click on the Screen Example to see an example of the screen layout.

Meaningful Use Core Measure	Screen Example
Core Measure 1 – CPOE for Medication, Laboratory and Radiology Orders	Screen 1
Core Measure 2 – ePrescribing (eRx)	Screen 2
Core Measure 3 – Record Demographics	Screen 3
Core Measure 4 – Record Vital Signs	Screen 4
Core Measure 5 – Record Smoking Status	Screen 5
Core Measure 6 – Clinical Decision Support Rule	Screen 6
Core Measure 7 – Patient Electronic Access	Screen 7
Core Measure 8 – Clinical Summaries	Screen 5
Core Measure 9 – Protect Electronic Health Information	Screen 8
Core Measure 10 – Clinical Lab-Test Results	Screen 5
Core Measure 11 – Patient Lists	Screen 8
Core Measure 12 – Preventive Care	Screen 5
Core Measure 13 – Patient-Specific Education Resources	Screen 5
Core Measure 14 – Medication Reconciliation	Screen 9
Core Measure 15 – Summary of Care	Screen 10
Core Measure 16 – Immunization Registries Data Submission	Screen 11
Core Measure 17 – Use Secure Electronic Messaging	Screen 9

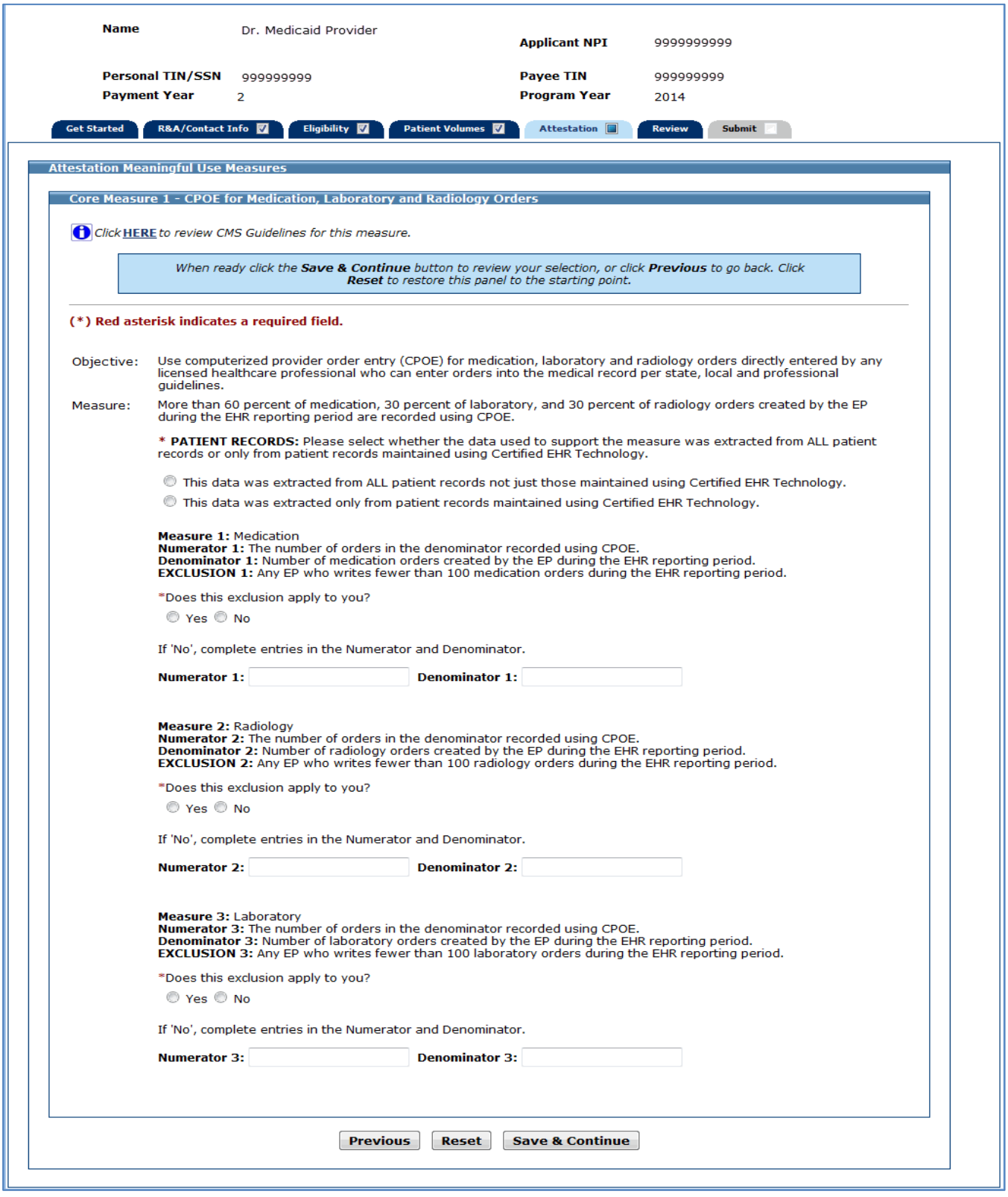
There are 17 Meaningful Use Core Measure screens. As you proceed through the Meaningful Use Core Measure section of MAPIR, you will see 11 different screen layouts. Instructions for each measure are provided on the screen. For additional help with a specific Meaningful Use Core Measure, click on the link provided above the blue instruction box.

Screen layout examples are shown on the following pages.

Screen 1

The following Meaningful Use Core Measure uses this screen layout:

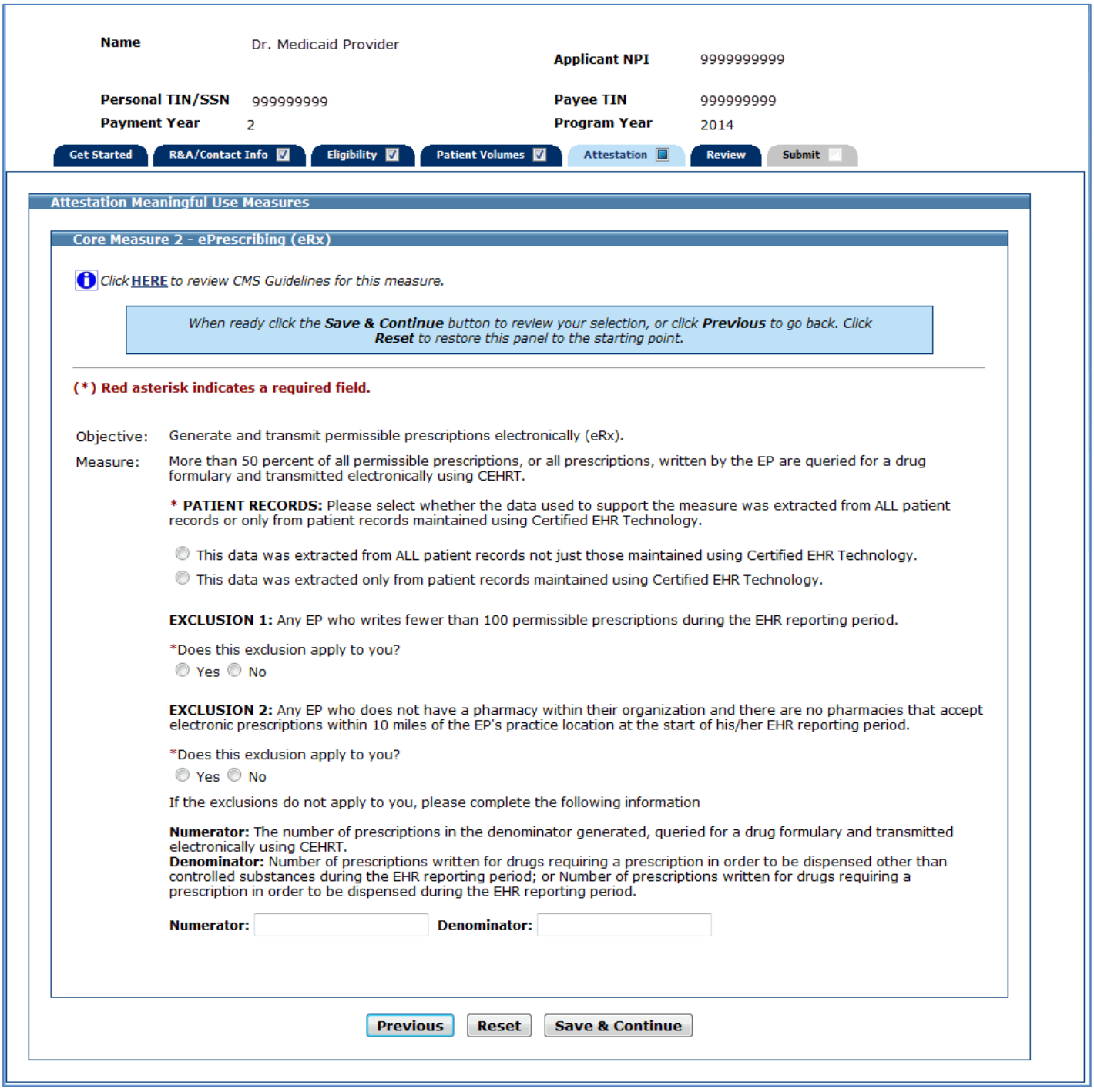
Core Measure 1


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 1 - CPOE for Medication, Laboratory and Radiology Orders
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Measure:
More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using Certified EHR Technology.
This data was extracted only from patient records maintained using Certified EHR Technology.
Measure 1: Medication
Numerator 1: The number of orders in the denominator recorded using CPOE.
Denominator 1: Number of medication orders created by the EP during the EHR reporting period.
EXCLUSION 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.
*Does this exclusion apply to you?
Yes No
If 'No', complete entries in the Numerator and Denominator.
Numerator 1:
Denominator 1:
Measure 2: Radiology
Numerator 2: The number of orders in the denominator recorded using CPOE.
Denominator 2: Number of radiology orders created by the EP during the EHR reporting period.
EXCLUSION 2: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.
*Does this exclusion apply to you?
Yes No
If 'No', complete entries in the Numerator and Denominator.
Numerator 2:
Denominator 2:
Measure 3: Laboratory
Numerator 3: The number of orders in the denominator recorded using CPOE.
Denominator 3: Number of laboratory orders created by the EP during the EHR reporting period.
EXCLUSION 3: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.
*Does this exclusion apply to you?
Yes No
If 'No', complete entries in the Numerator and Denominator.
Numerator 3:
Denominator 3:
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Core Measure uses this screen layout:

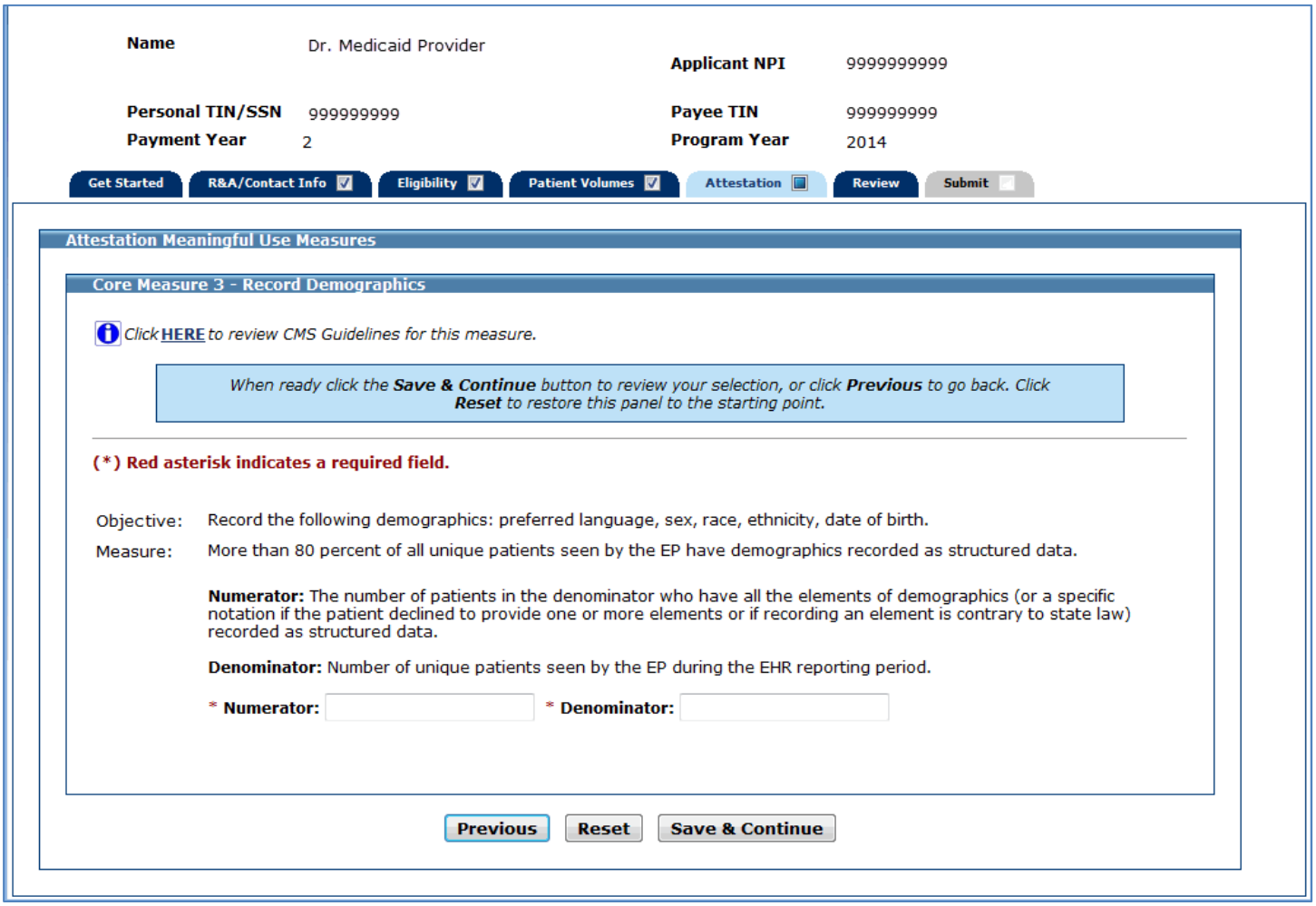
Core Measure 2


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 2 - ePrescribing (eRx)
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Generate and transmit permissible prescriptions electronically (eRx).
Measure:
More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using Certified EHR Technology.
This data was extracted only from patient records maintained using Certified EHR Technology.
EXCLUSION 1: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period.
*Does this exclusion apply to you?
Yes No
EXCLUSION 2: Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
*Does this exclusion apply to you?
Yes No
If the exclusions do not apply to you, please complete the following information
Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.
Numerator:
Denominator:
Previous
Reset
Save & Continue

Screen 3

The following Meaningful Use Core Measure uses this screen layout:

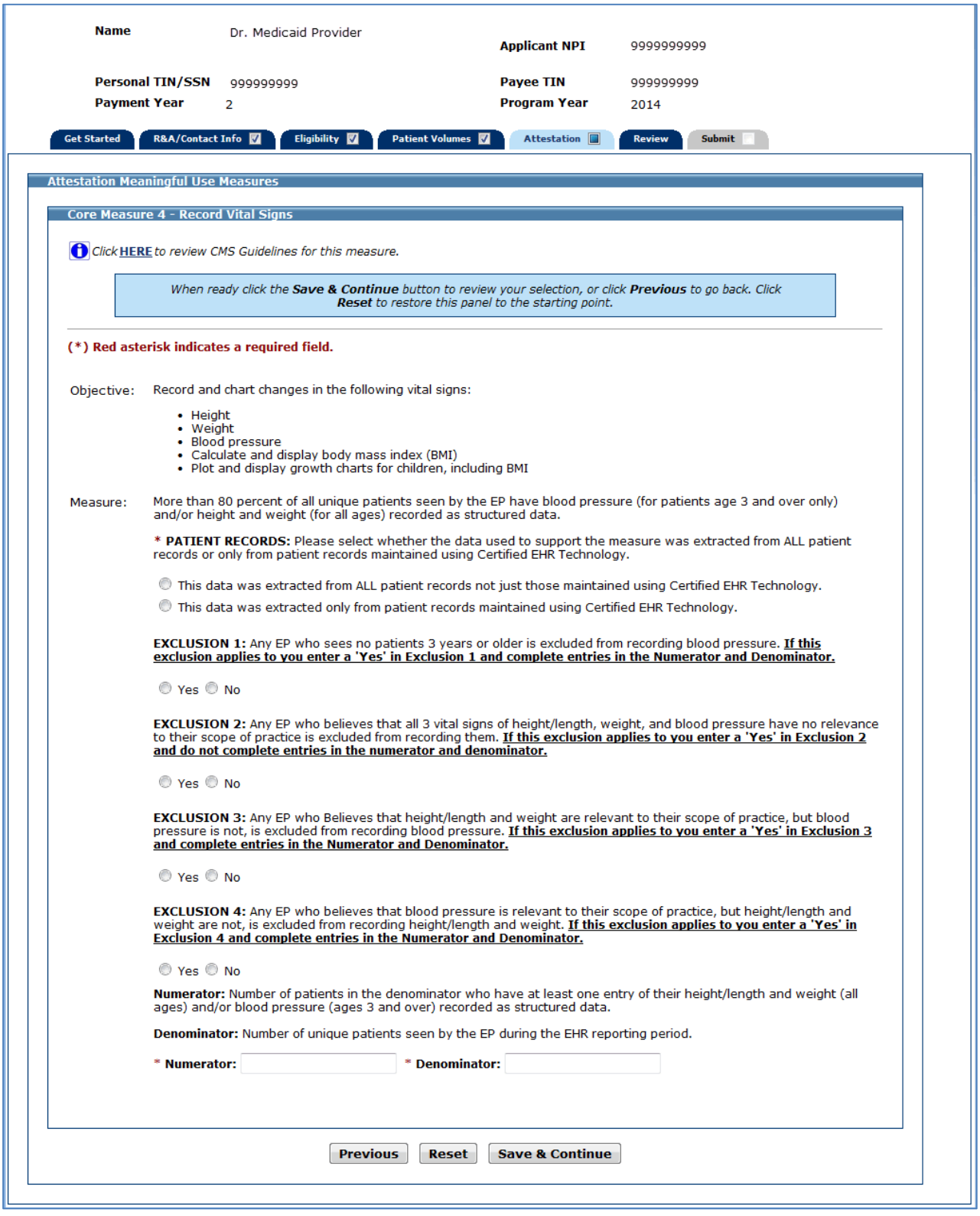
Core Measure 3


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 3 - Record Demographics
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Record the following demographics: preferred language, sex, race, ethnicity, date of birth.
Measure:
More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.
Numerator: The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 4

The following Meaningful Use Core Measure uses this screen layout:

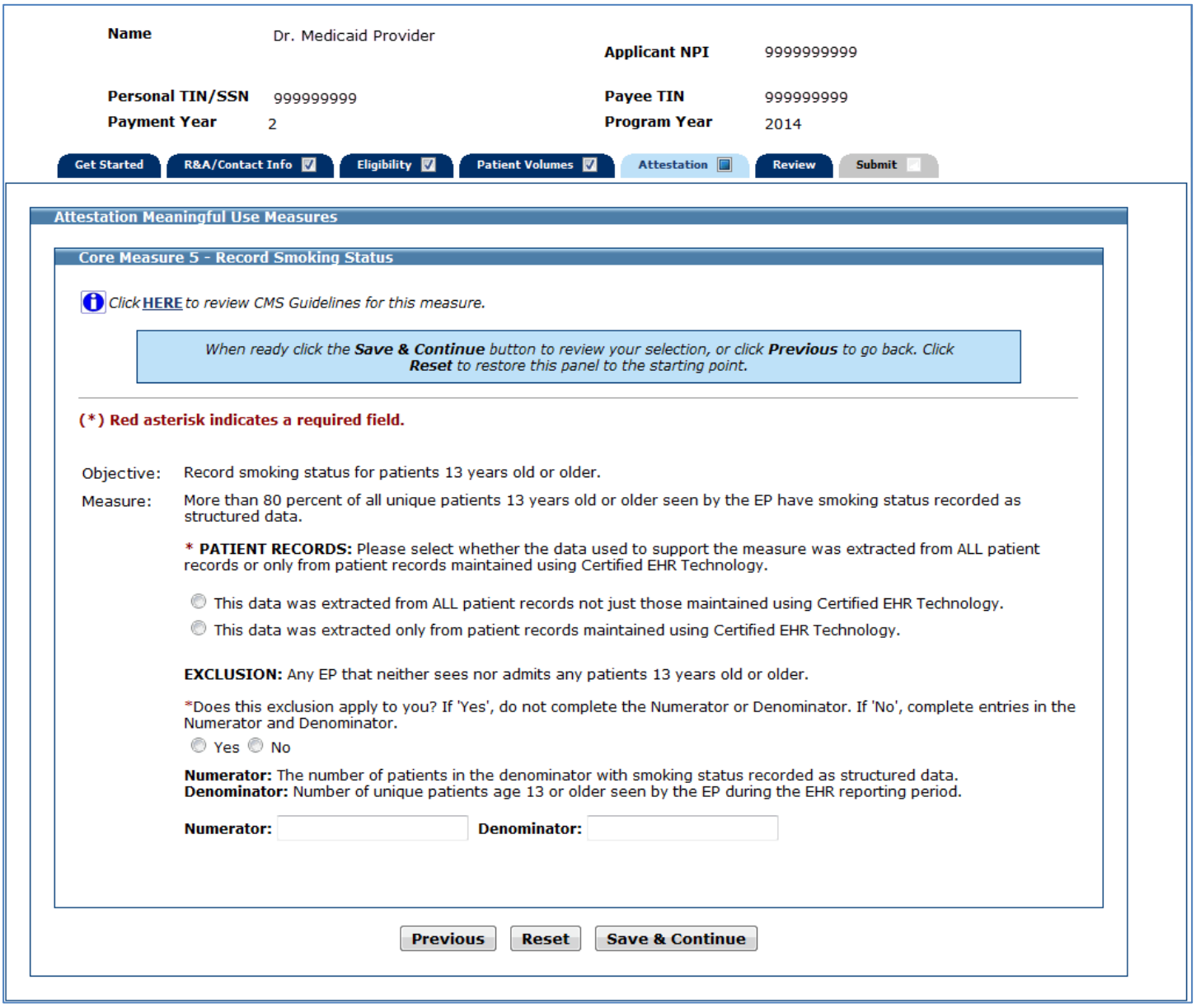
Core Measure 4


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 4 - Record Vital Signs
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Record and chart changes in the following vital signs:
Height
Weight
Blood pressure
Calculate and display body mass index (BMI)
Plot and display growth charts for children, including BMI
Measure:
More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using Certified EHR Technology.
This data was extracted only from patient records maintained using Certified EHR Technology.
EXCLUSION 1: Any EP who sees no patients 3 years or older is excluded from recording blood pressure. If this exclusion applies to you enter a 'Yes' in Exclusion 1 and complete entries in the Numerator and Denominator.
Yes No
EXCLUSION 2: Any EP who believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. If this exclusion applies to you enter a 'Yes' in Exclusion 2 and do not complete entries in the numerator and denominator.
Yes No
EXCLUSION 3: Any EP who Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. If this exclusion applies to you enter a 'Yes' in Exclusion 3 and complete entries in the Numerator and Denominator.
Yes No
EXCLUSION 4: Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight. If this exclusion applies to you enter a 'Yes' in Exclusion 4 and complete entries in the Numerator and Denominator.
Yes No
Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:
Previous
Reset
Save & Continue

Screen 5

The following Meaningful Use Core Measure uses this screen layout:

Core Measure 5, 8, 10, 12, 13


Name
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Payee TIN
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Payment Year
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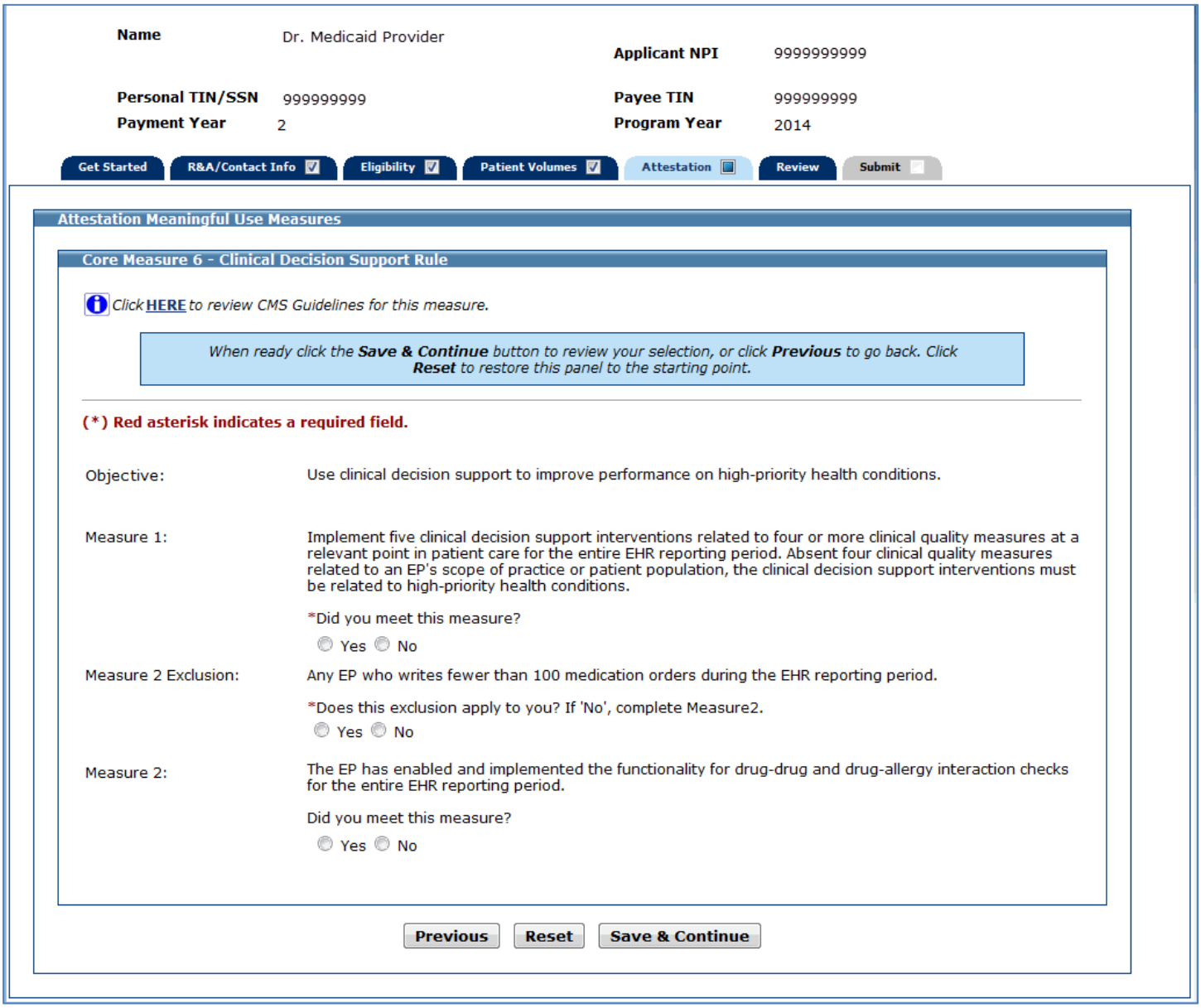
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 5 - Record Smoking Status
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Record smoking status for patients 13 years old or older.
Measure:
More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified EHR Technology.
This data was extracted from ALL patient records not just those maintained using Certified EHR Technology.
This data was extracted only from patient records maintained using Certified EHR Technology.
EXCLUSION: Any EP that neither sees nor admits any patients 13 years old or older.
*Does this exclusion apply to you? If 'Yes', do not complete the Numerator or Denominator. If 'No', complete entries in the Numerator and Denominator.
Yes
No
Numerator: The number of patients in the denominator with smoking status recorded as structured data.
Denominator: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
Numerator:
Denominator:
Previous
Reset
Save & Continue

Screen 6

The following Meaningful Use Core Measure uses this screen layout:

Core Measure 6


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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Payee TIN
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Payment Year
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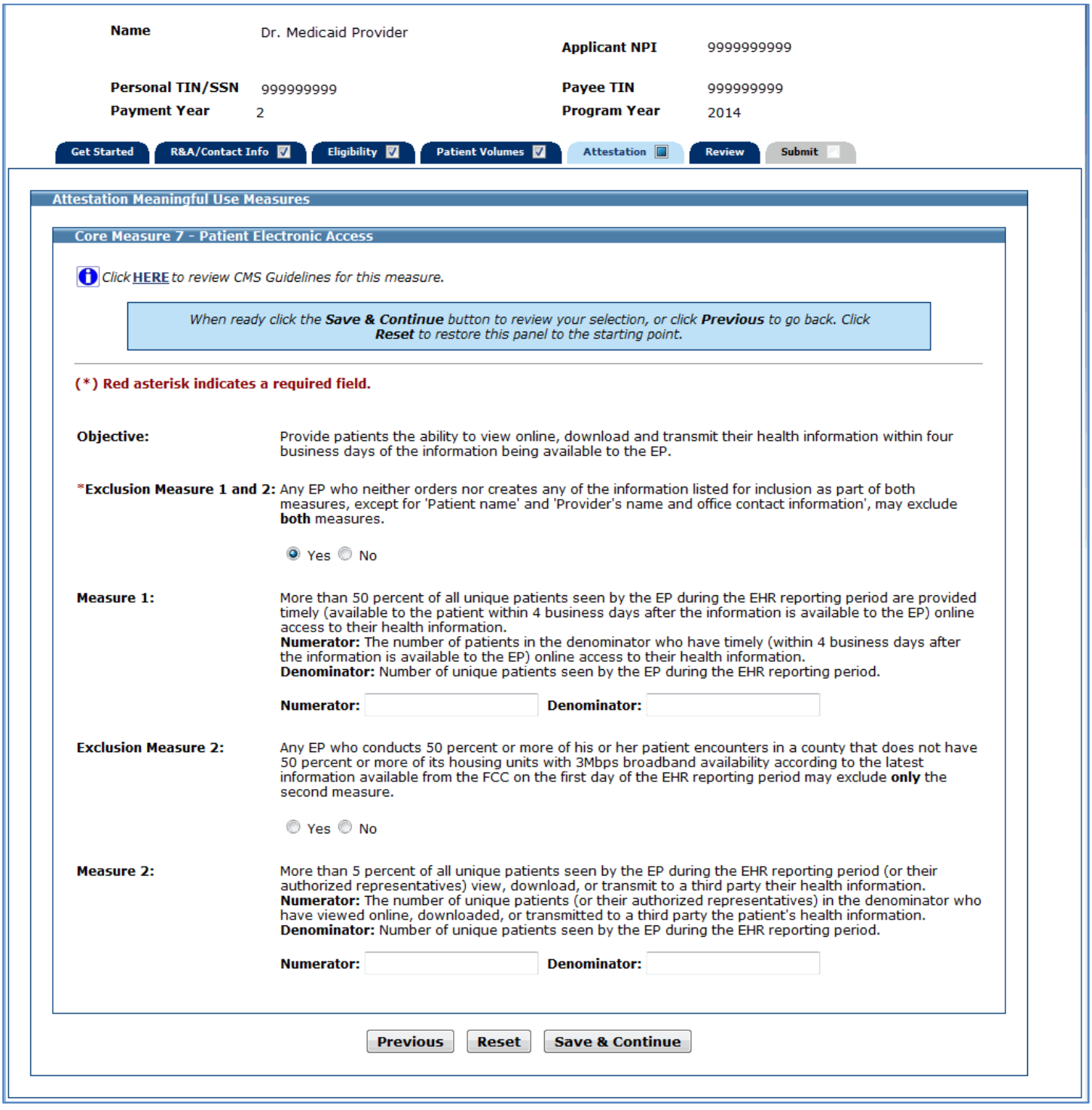
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 6 - Clinical Decision Support Rule
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Use clinical decision support to improve performance on high-priority health conditions.
Measure 1:
Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.
*Did you meet this measure?
Yes No
Measure 2 Exclusion:
Any EP who writes fewer than 100 medication orders during the EHR reporting period.
*Does this exclusion apply to you? If 'No', complete Measure2.
Yes No
Measure 2:
The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Did you meet this measure?
Yes No
Previous
Reset
Save & Continue

Screen 7

The following Meaningful Use Core Measure uses this screen layout:

Core Measure 7


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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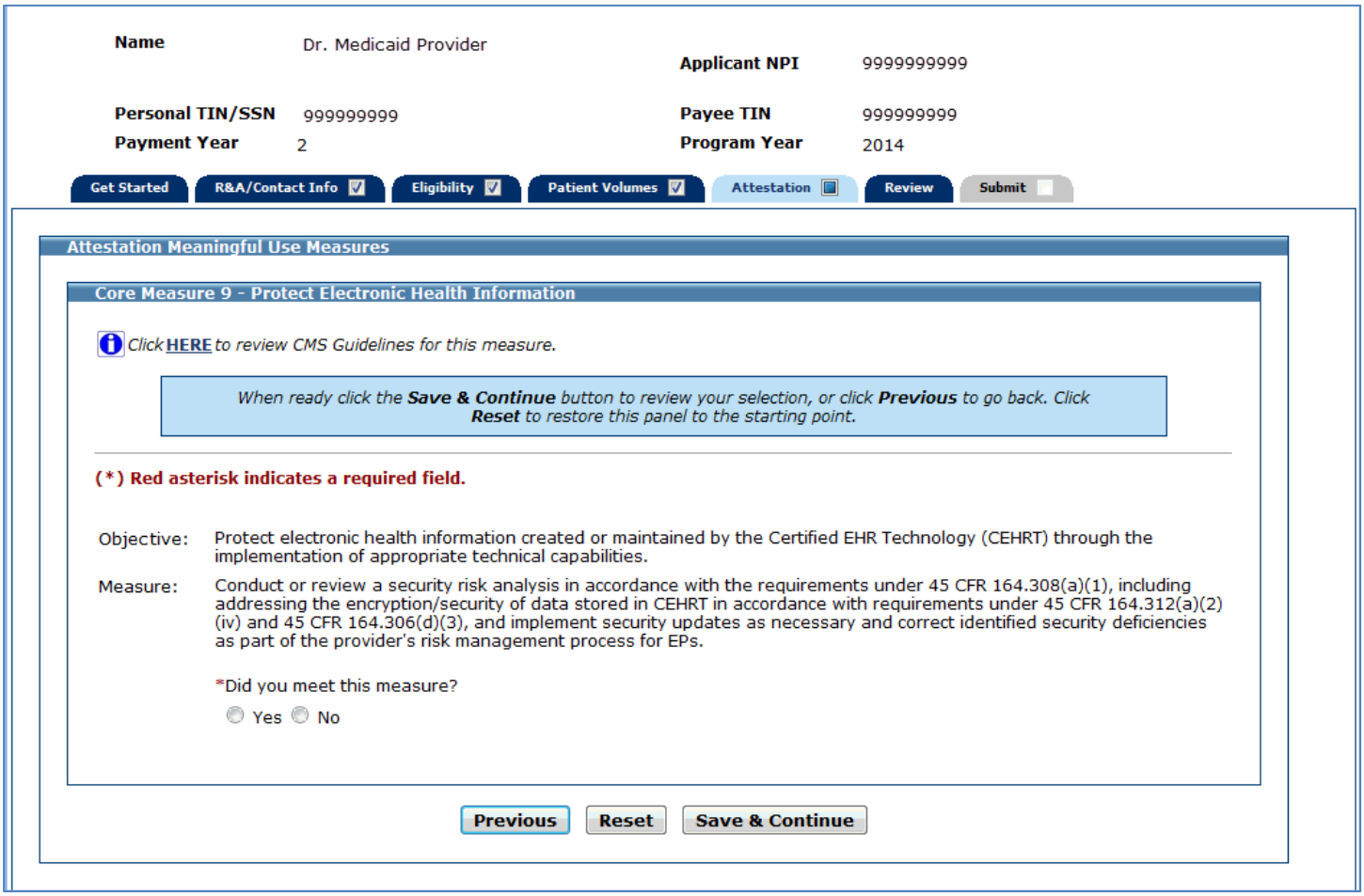
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 7 - Patient Electronic Access
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
*Exclusion Measure 1 and 2:
Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for 'Patient name' and 'Provider's name and office contact information', may exclude both measures.
Yes
No
Measure 1:
More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.
Numerator: The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
Numerator:
Denominator:
Exclusion Measure 2:
Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.
Yes
No
Measure 2:
More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.
Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
Numerator:
Denominator:
Previous
Reset
Save & Continue

Screen 8

The following Meaningful Use Core Measure uses this screen layout:

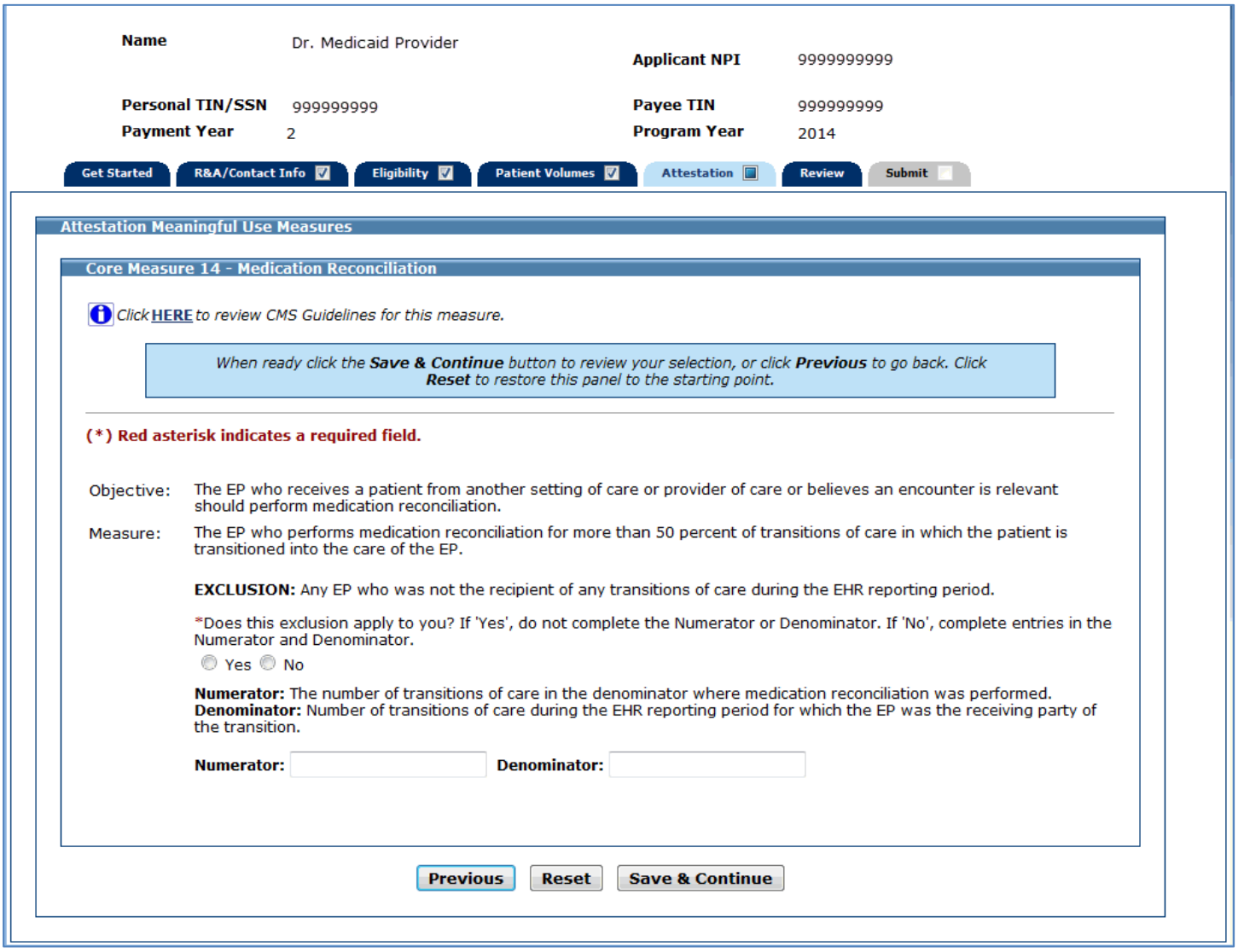
Core Measure 9 and 11


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 9 - Protect Electronic Health Information
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Protect electronic health information created or maintained by the Certified EHR Technology (CEHRT) through the implementation of appropriate technical capabilities.
Measure:
Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.
*Did you meet this measure?
Yes
No
Previous
Reset
Save & Continue

Screen 9

The following Meaningful Use Core Measure uses this screen layout:

Core Measure 14 and 17


Name
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Payee TIN
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Payment Year
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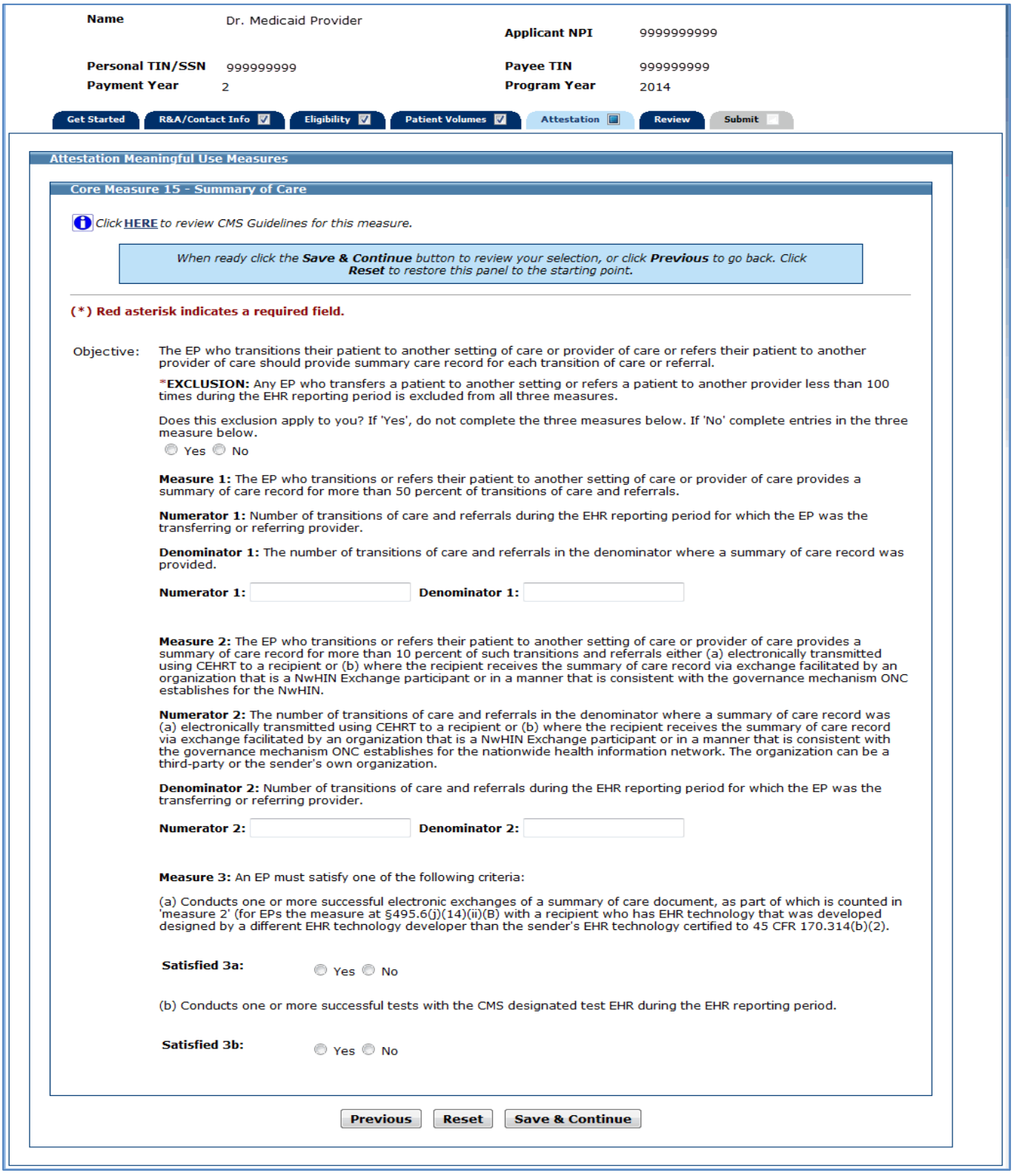
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 14 - Medication Reconciliation
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
Measure:
The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
EXCLUSION: Any EP who was not the recipient of any transitions of care during the EHR reporting period.
*Does this exclusion apply to you? If 'Yes', do not complete the Numerator or Denominator. If 'No', complete entries in the Numerator and Denominator.
Yes
No
Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.
Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
Numerator:
Denominator:
Previous
Reset
Save & Continue

Screen 10

The following Meaningful Use Core Measure uses this screen layout:

Core Measure 15


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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Payee TIN
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Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 15 - Summary of Care
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
*EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.
Does this exclusion apply to you? If 'Yes', do not complete the three measures below. If 'No' complete entries in the three measure below.
Yes No
Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Numerator 1: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
Denominator 1: The number of transitions of care and referrals in the denominator where a summary of care record was provided.
Numerator 1:
Denominator 1:
Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.
Numerator 2: The number of transitions of care and referrals in the denominator where a summary of care record was (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.
Denominator 2: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
Numerator 2:
Denominator 2:
Measure 3: An EP must satisfy one of the following criteria:
(a) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in 'measure 2' (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).
Satisfied 3a:
Yes No
(b) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Satisfied 3b:
Yes No
Previous
Reset
Save & Continue

Screen 11

The following Meaningful Use Core Measure uses this screen layout:

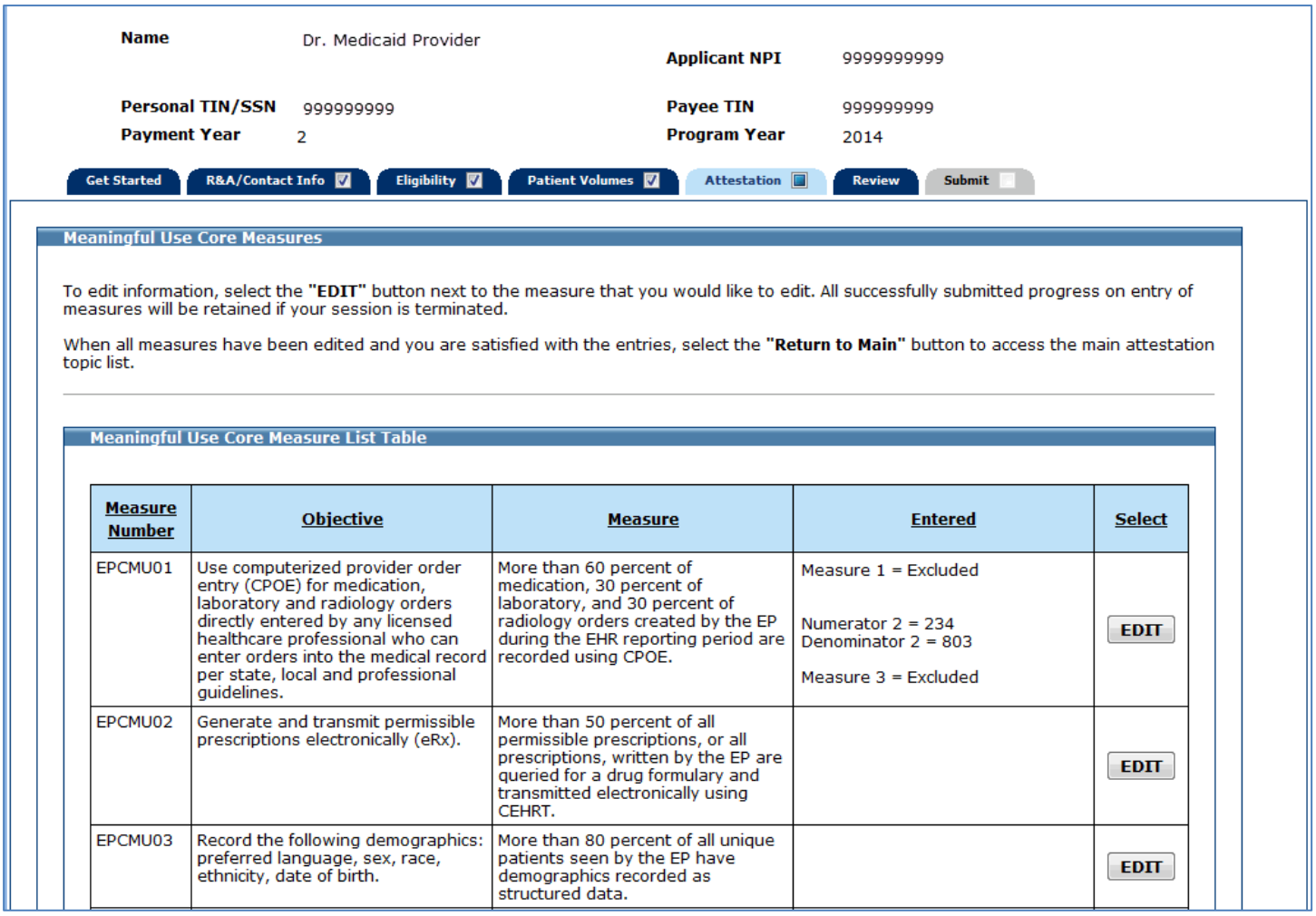
Core Measure 16

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 16 - Immunization Registries Data Submission
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective:
Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.
Measure:
Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.
The Eligible Professional must attest Yes or No to the following criteria under the umbrella of ongoing submission:
*Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved.
Yes No
*Registration with the public health agency or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission as achieved.
Yes No
*Registration of intent to initiate ongoing submission was made by the deadline and the authorized provider or hospital is still engaged in testing and validation of ongoing electronic submission.
Yes No
*Registration of intent to initiate ongoing submission was made by the deadline and the authorized provider or hospital is awaiting invitation to begin testing and validation.
Yes No
EXCLUSIONS: If any of the measures above are 'Yes', then do not select an Exclusion. If all of the above measures are 'No', then select one or more of the Exclusions below. Any Eligible Professional that meets one or more of the following criteria may be excluded from this objective.
Does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.
Yes No
Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period.
Yes No
Operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.
Yes No
Operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional EPs.
Yes No
Previous
Reset
Save & Continue

After you enter information for a measure, click the **Save & Continue.** You will be returned to the Meaningful Use Core Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

Click **Edit** for the next measure.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 2 **Program Year** 2014

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Meaningful Use Core Measures

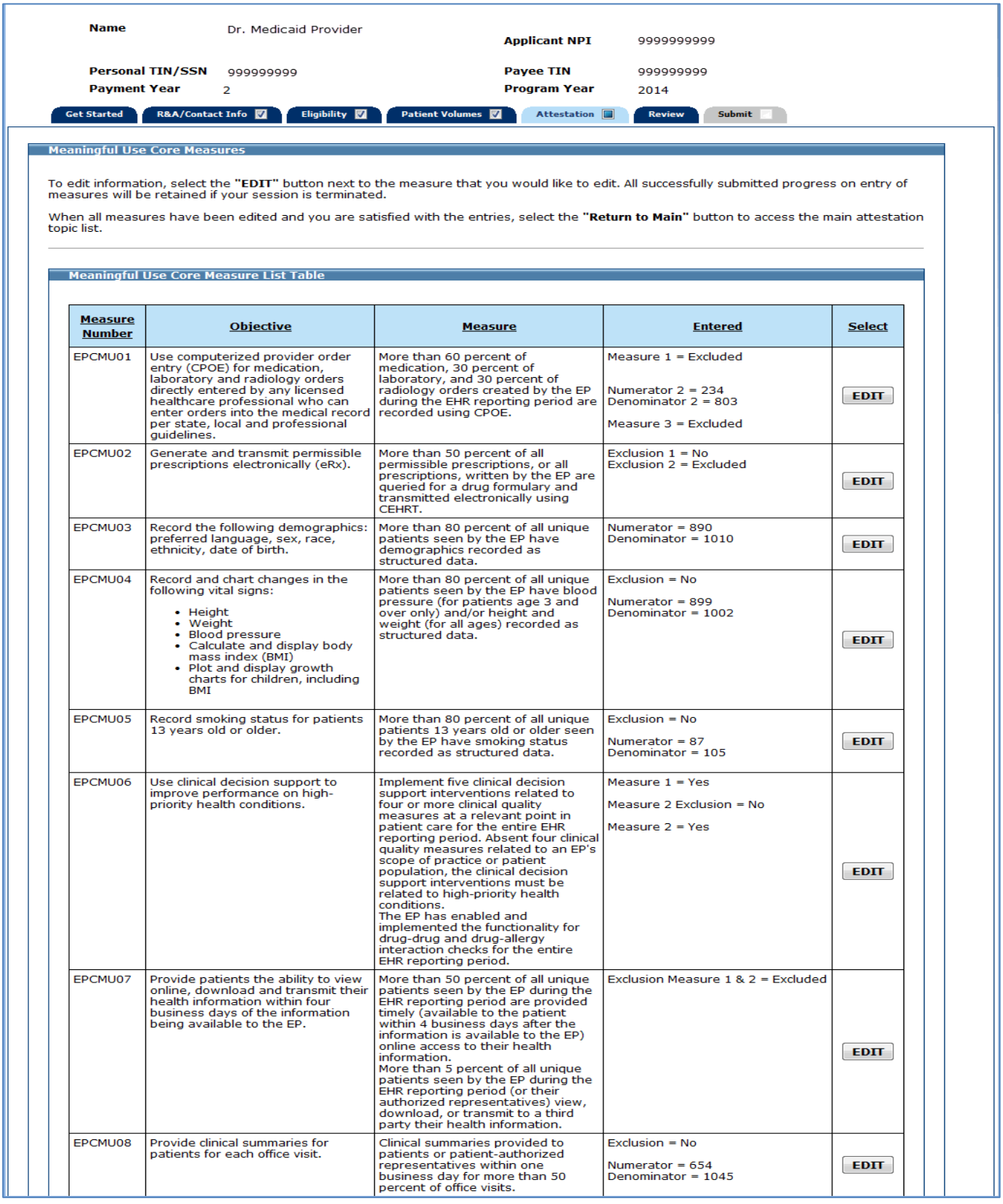
To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Measure 1 = Excluded Numerator 2 = 234 Denominator 2 = 803 Measure 3 = Excluded	EDIT
EPCMU02	Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.		EDIT
EPCMU03	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.		EDIT

Once you have attested to all the measures for this topic, click **Return to Main** to return to the Measures Topic List.



Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 2
Program Year 2014

Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

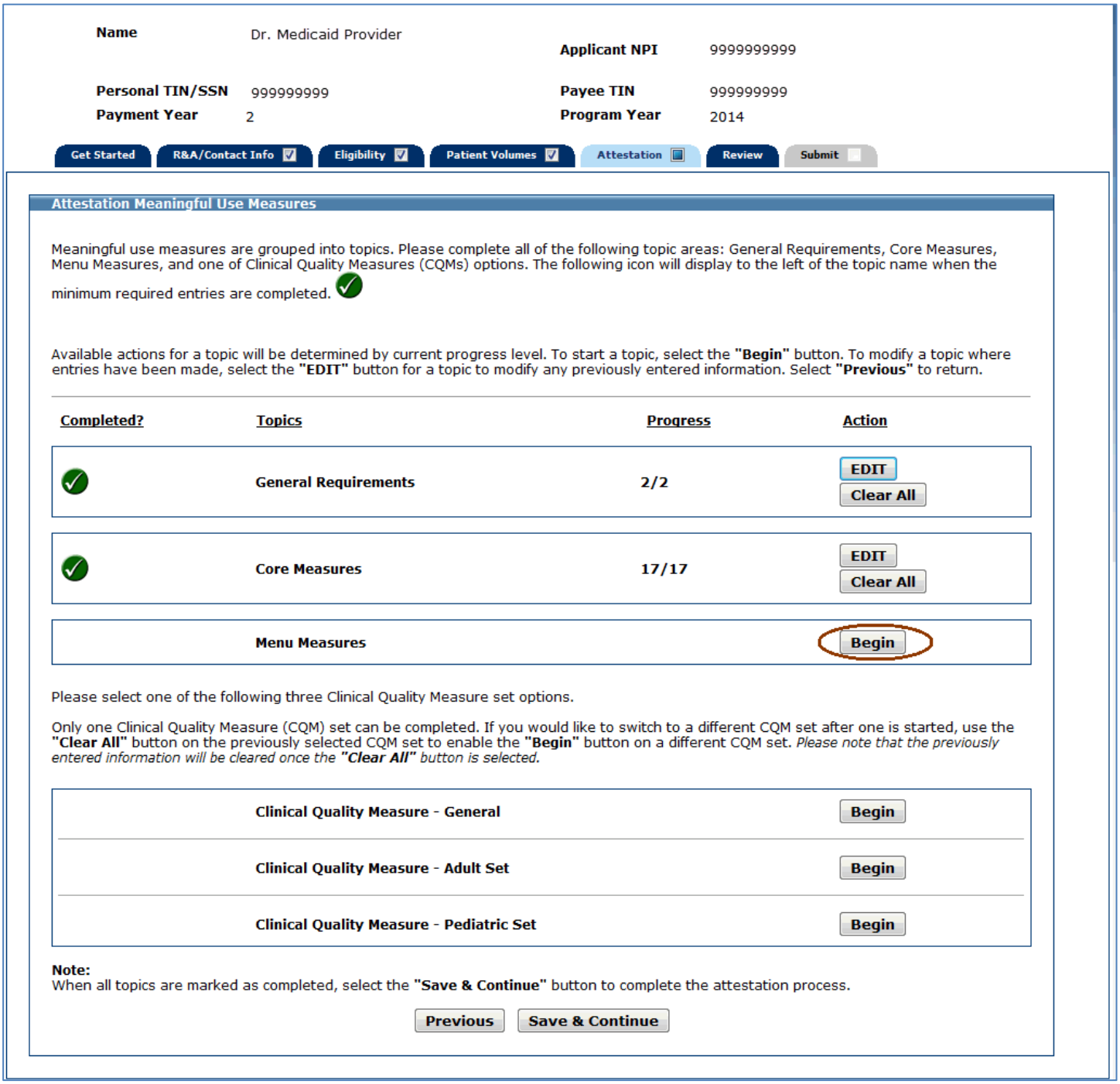
Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Measure 1 = Excluded Numerator 2 = 234 Denominator 2 = 803 Measure 3 = Excluded	EDIT
EPCMU02	Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	Exclusion 1 = No Exclusion 2 = Excluded	EDIT
EPCMU03	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.	Numerator = 890 Denominator = 1010	EDIT
EPCMU04	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children, including BMI	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.	Exclusion = No Numerator = 899 Denominator = 1002	EDIT
EPCMU05	Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Exclusion = No Numerator = 87 Denominator = 105	EDIT
EPCMU06	Use clinical decision support to improve performance on high-priority health conditions.	Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Measure 1 = Yes Measure 2 Exclusion = No Measure 2 = Yes	EDIT
EPCMU07	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.	Exclusion Measure 1 & 2 = Excluded	EDIT
EPCMU08	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.	Exclusion = No Numerator = 654 Denominator = 1045	EDIT

EPCMU08	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.	Exclusion = No Numerator = 654 Denominator = 1045	EDIT
EPCMU09	Protect electronic health information created or maintained by the Certified EHR Technology (CEHRT) through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.	Yes	EDIT
EPCMU10	Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.	More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.	Exclusion = Excluded	EDIT
EPCMU11	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes	EDIT
EPCMU12	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.	More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.	Exclusion = No Numerator = 176 Denominator = 897	EDIT
EPCMU13	Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.	Exclusion = Excluded	EDIT
EPCMU14	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	Exclusion = No Numerator = 687 Denominator = 1056	EDIT
EPCMU15	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. An EP must satisfy one of the following criteria: (a) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). (b) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	Exclusion = No Numerator 1 = 80 Denominator 1 = 100 Numerator 2 = 87 Denominator 2 = 107 Measure 3 = Satisfied a = Yes Satisfied b = Yes	EDIT
EPCMU16	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.	Q1 = Yes Q2 = Yes Q3 = Yes Q4 = Yes	EDIT
EPCMU17	Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	Exclusion = No Numerator = 58 Denominator = 200	EDIT

Return to Main

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, or click **Clear All** to clear all topic information you entered. Click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
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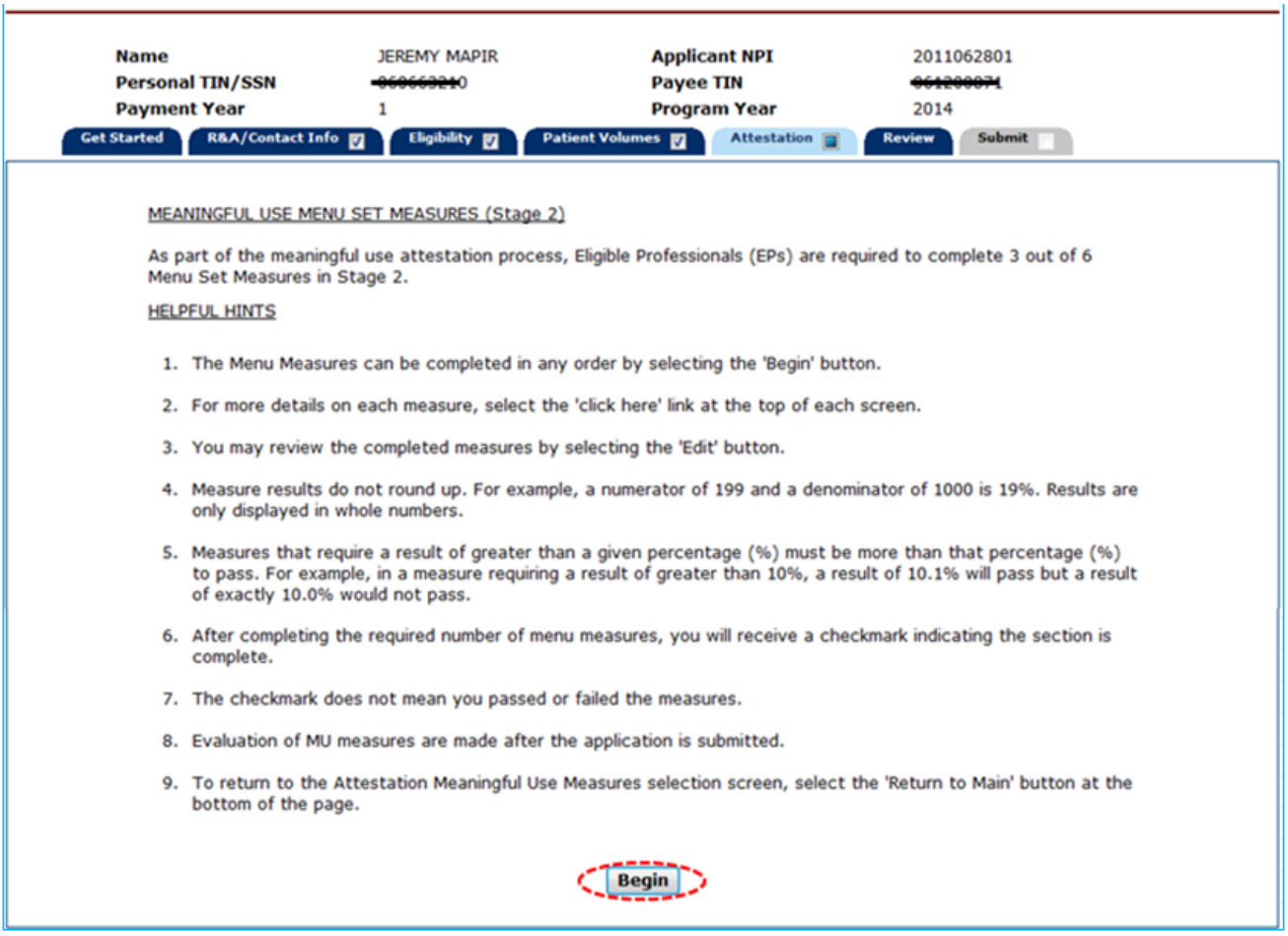
Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
17/17
EDIT
Clear All
Menu Measures
Begin
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
Begin
Clinical Quality Measure - Adult Set
Begin
Clinical Quality Measure - Pediatric Set
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Menu Set Measures

This initial screen provides information about the Meaningful Use Menu Measures for Stage 2.

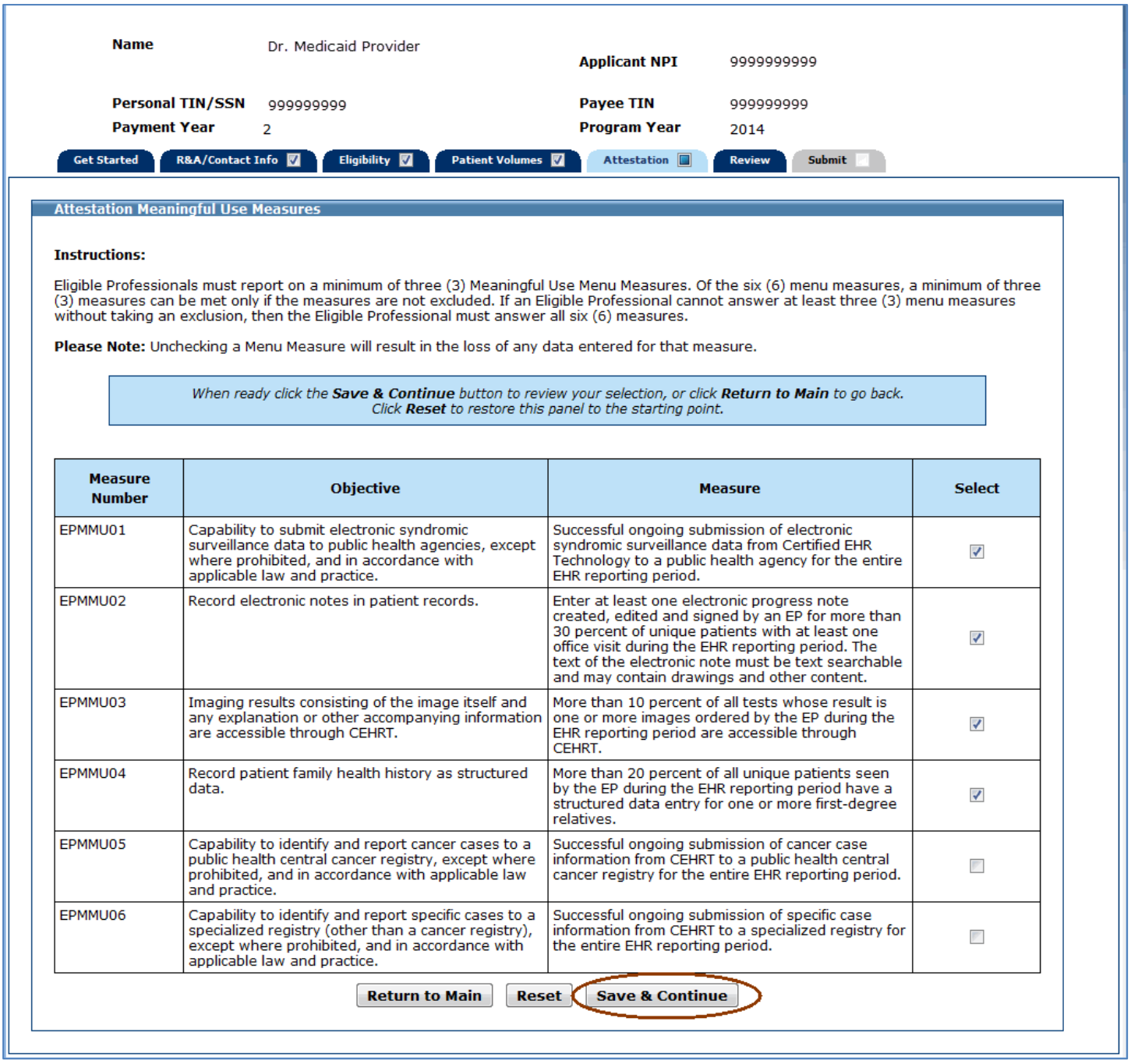
Click **Begin** to continue to the Meaningful Use Menu Measures Selection screen.


Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN [redacted]
Payee TIN [redacted]
Payment Year 1
Program Year 2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE MENU SET MEASURES (Stage 2)
As part of the meaningful use attestation process, Eligible Professionals (EPs) are required to complete 3 out of 6 Menu Set Measures in Stage 2.
HELPFUL HINTS
1. The Menu Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 10%, a result of 10.1% will pass but a result of exactly 10.0% would not pass.
6. After completing the required number of menu measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Begin

From the Meaningful Use Menu Measures Selection screen, choose a minimum of three Meaningful Use Menu Measures to attest to.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return** to go back. Click **Reset** to restore this panel to the starting point.



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Personal TIN/SSN 999999999

Payee TIN 999999999

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Attestation Meaningful Use Measures

Instructions:

Eligible Professionals must report on a minimum of three (3) Meaningful Use Menu Measures. Of the six (6) menu measures, a minimum of three (3) measures can be met only if the measures are not excluded. If an Eligible Professional cannot answer at least three (3) menu measures without taking an exclusion, then the Eligible Professional must answer all six (6) measures.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

*When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.*

Measure Number	Objective	Measure	Select
EPMMU01	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.	☑
EPMMU02	Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	☑
EPMMU03	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	☑
EPMMU04	Record patient family health history as structured data.	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	☑
EPMMU05	Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.	☐
EPMMU06	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	☐

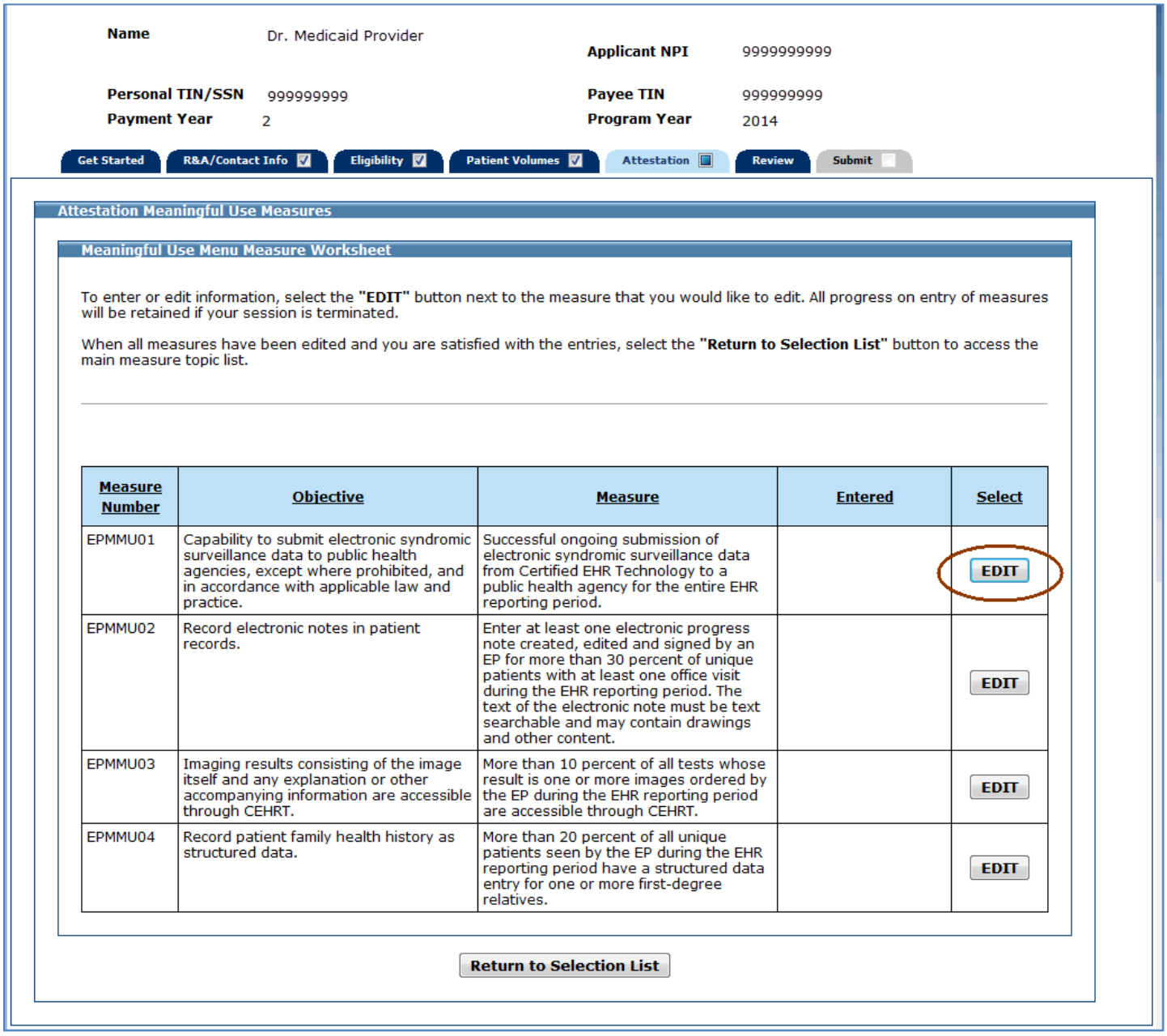
Return to Main | Reset | Save & Continue

The measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the four measures selected on the previous screen example.

You must complete all measures on this screen.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure, or click **Return to Selection List** to return to the Measures Topic List.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Menu Measure Worksheet
To enter or edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Selection List" button to access the main measure topic list.
Measure Number
Objective
Measure
Entered
Select
EPMMU01
Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.
Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.
EDIT
EPMMU02
Record electronic notes in patient records.
Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.
EDIT
EPMMU03
Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.
More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.
EDIT
EPMMU04
Record patient family health history as structured data.
More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.
EDIT
Return to Selection List

The following is a list of the six Meaningful Use Menu Measures that you may attest to.

Click on the Screen Example to see an example of the screen layout.

Meaningful Use Menu Measure	Screen Example
Menu Measure 1 - Syndromic Surveillance Data Submission	Screen 1
Menu Measure 2 - Electronic Notes	Screen 2
Menu Measure 3 - Imaging Results	Screen 2
Menu Measure 4 - Family Health History	Screen 2
Menu Measure 5 - Report Cancer Cases	Screen 1
Menu Measure 6 - Report Specific Cases	Screen 1

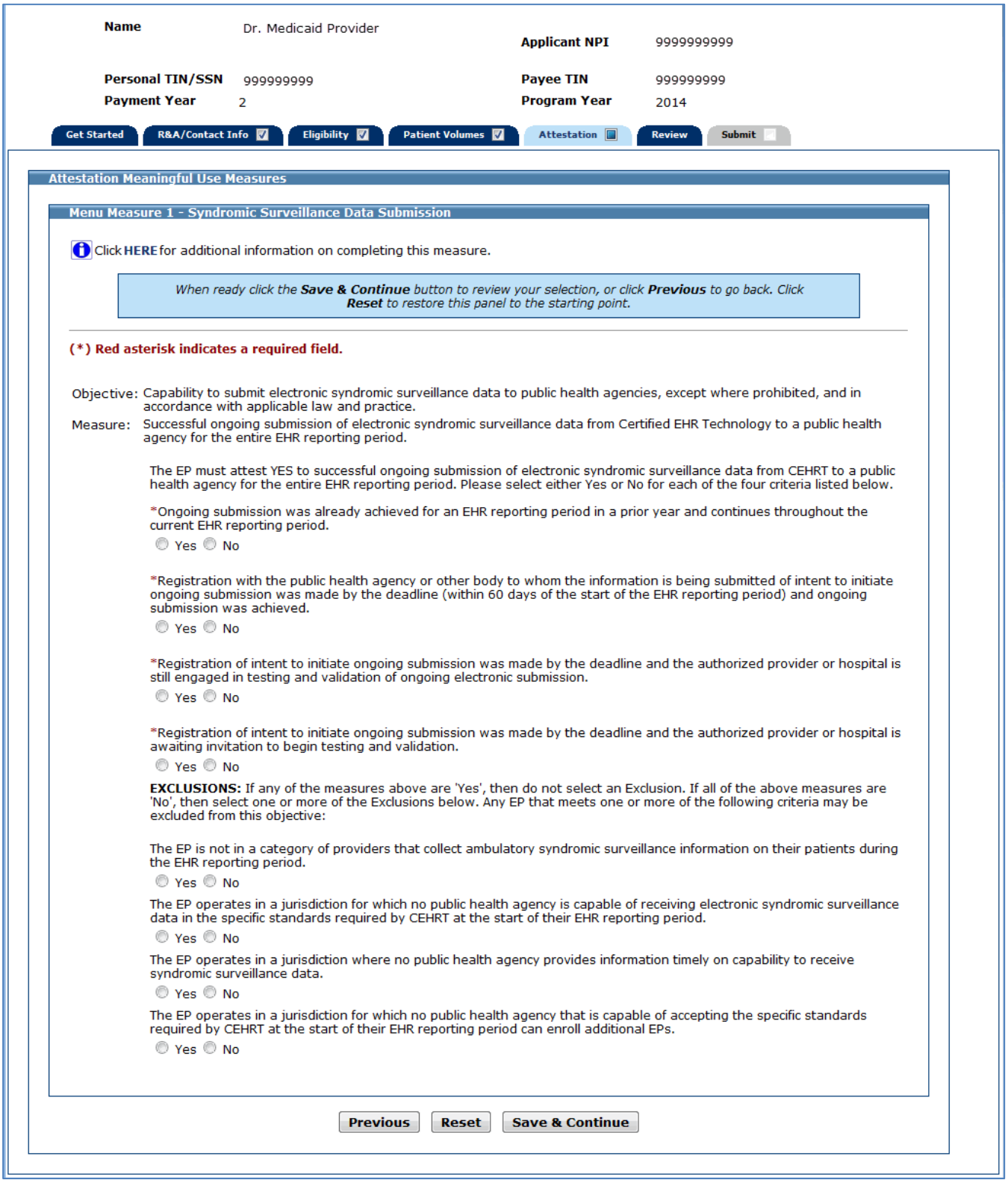
There are six Meaningful Use Menu Measure screens. As you proceed through the Meaningful Use Menu Measure section of MAPIR, you will see two different screen layouts. Instructions for each measure are provided on the screen. For additional help with a specific Meaningful Use Menu Measure, click on the link provided above the blue instruction box.

Screen layout examples are shown on the following pages.

Screen 1

The following Meaningful Use Menu Measures use this screen layout:

Menu Measures 1, 5, and 6


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 1 - Syndromic Surveillance Data Submission
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.
Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.
The EP must attest YES to successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period. Please select either Yes or No for each of the four criteria listed below.
*Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.
Yes No
*Registration with the public health agency or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
Yes No
*Registration of intent to initiate ongoing submission was made by the deadline and the authorized provider or hospital is still engaged in testing and validation of ongoing electronic submission.
Yes No
*Registration of intent to initiate ongoing submission was made by the deadline and the authorized provider or hospital is awaiting invitation to begin testing and validation.
Yes No
EXCLUSIONS: If any of the measures above are 'Yes', then do not select an Exclusion. If all of the above measures are 'No', then select one or more of the Exclusions below. Any EP that meets one or more of the following criteria may be excluded from this objective:
The EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period.
Yes No
The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period.
Yes No
The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data.
Yes No
The EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.
Yes No
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Menu Measures use this screen layout:

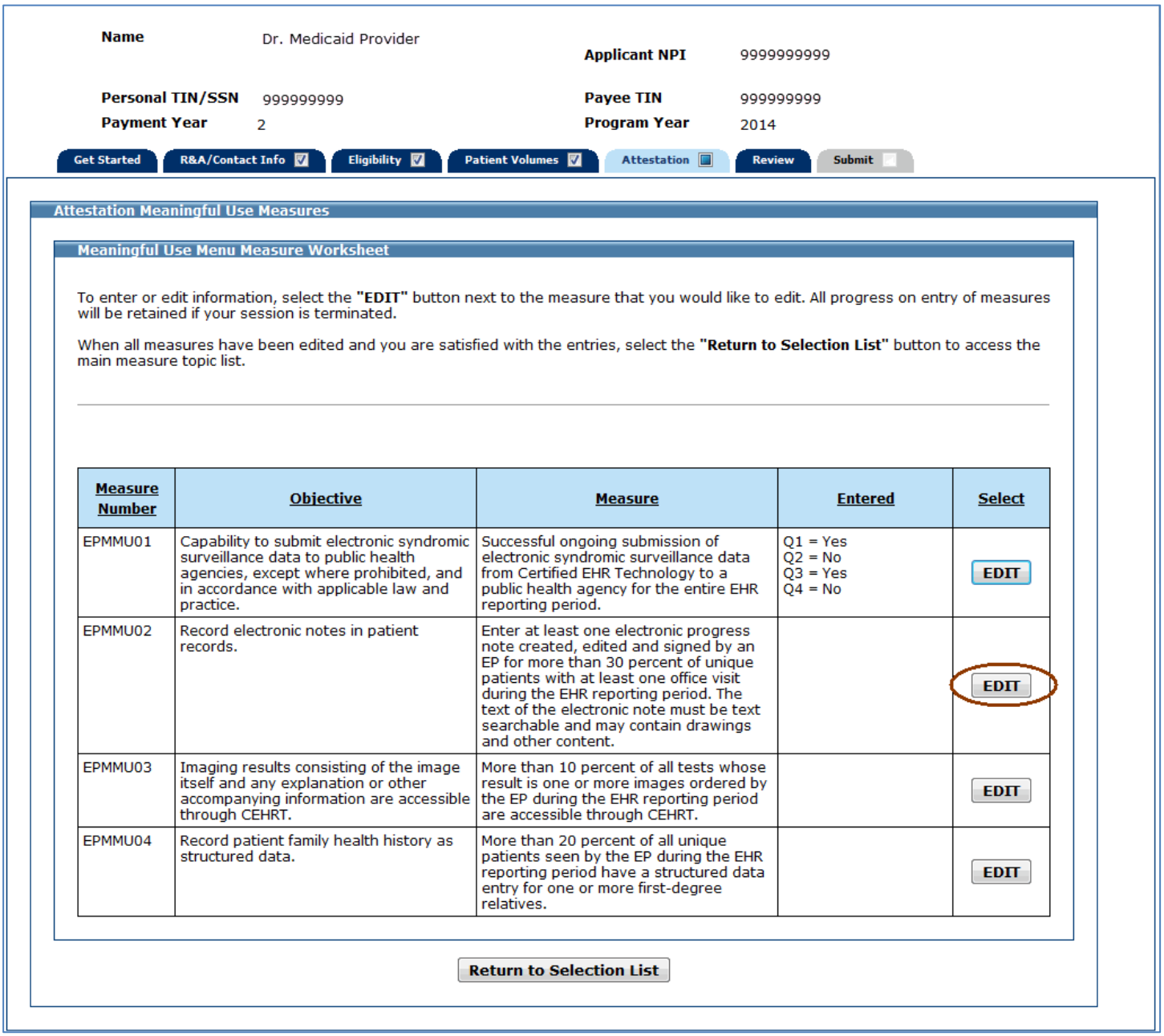
Menu Measures 2, 3, and 4

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 2 - Electronic Notes
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Record electronic notes in patient records.
Measure: Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.
EXCLUSION: Any EP who has no office visits during the EHR reporting period.
*Does this exclusion apply to you? If 'Yes', do not complete the Numerator or Denominator. If 'No', complete the entries in the Numerator and Denominator.
Yes No
Numerator = The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data.
Denominator = Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period.
Numerator:
Denominator:
Previous
Reset
Save & Continue

After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.



Name Dr. Medicaid Provider

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Payee TIN 999999999

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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

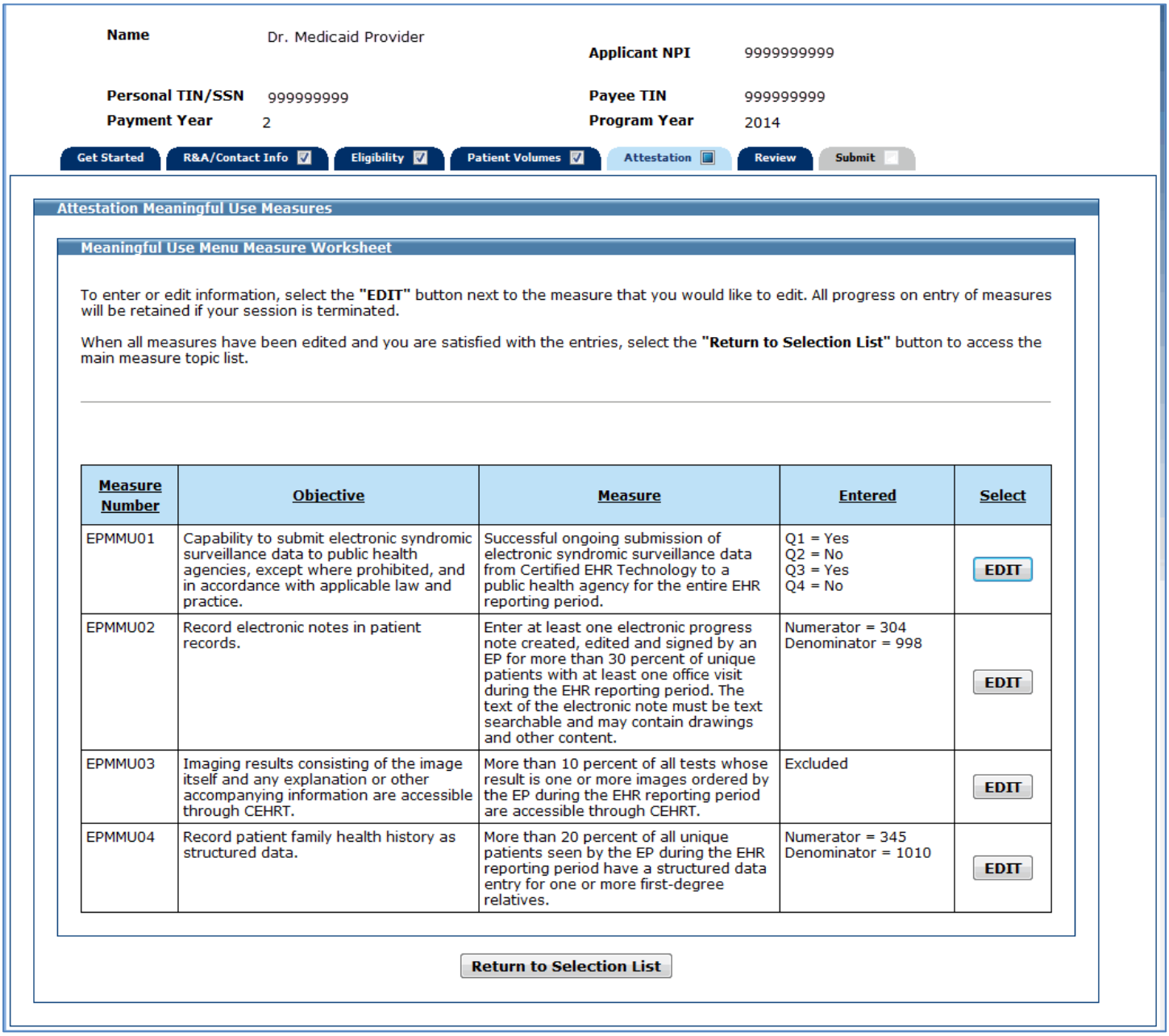
To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.	Q1 = Yes Q2 = No Q3 = Yes Q4 = No	EDIT
EPMMU02	Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.		EDIT
EPMMU03	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.		EDIT
EPMMU04	Record patient family health history as structured data.	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.		EDIT

Return to Selection List

Once you have attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Menu Measure Selection screen.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 2 **Program Year** 2014

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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.	Q1 = Yes Q2 = No Q3 = Yes Q4 = No	EDIT
EPMMU02	Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	Numerator = 304 Denominator = 998	EDIT
EPMMU03	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	Excluded	EDIT
EPMMU04	Record patient family health history as structured data.	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	Numerator = 345 Denominator = 1010	EDIT

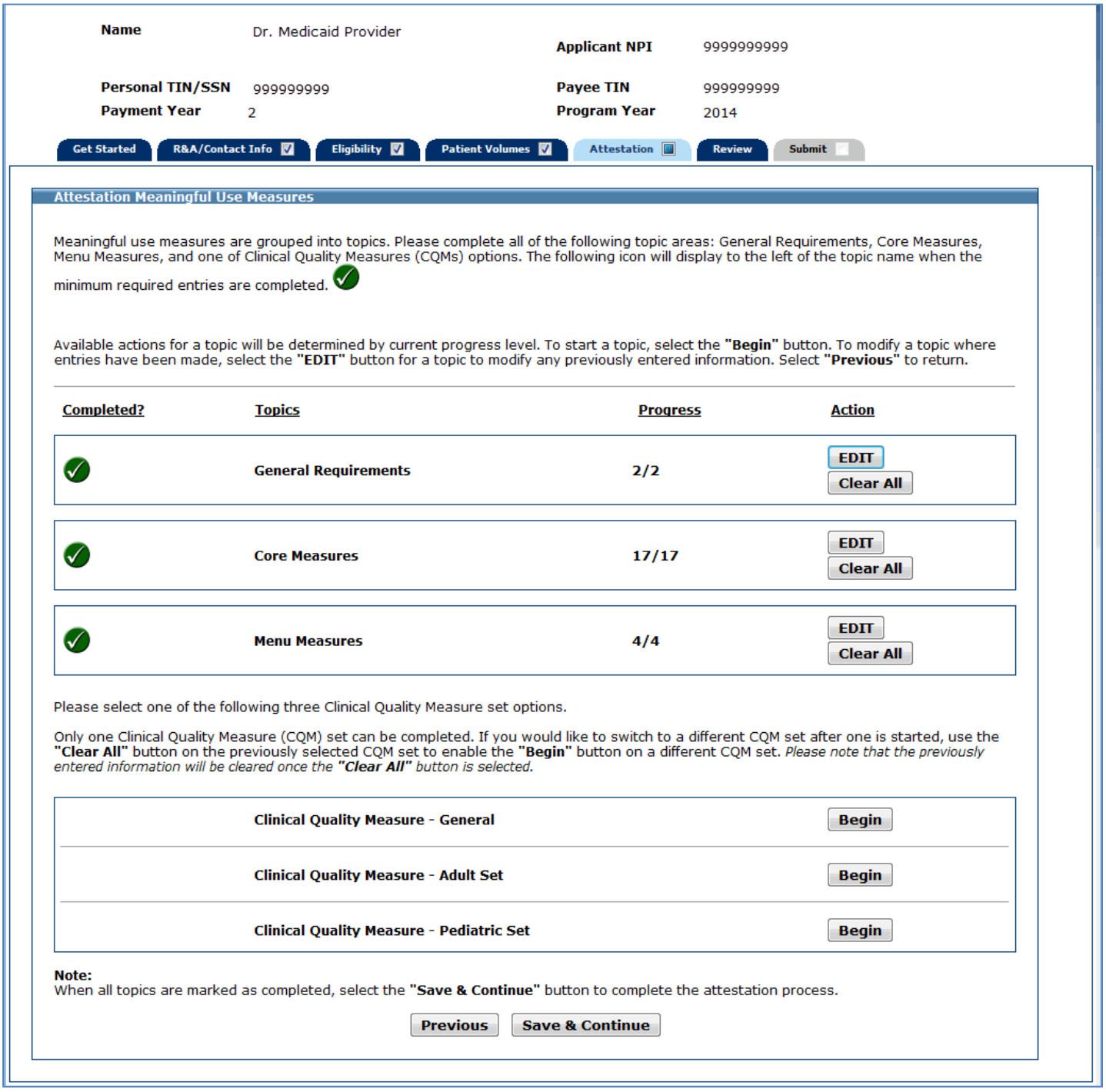
Return to Selection List

Click **Return to Main** to return to the Measure Topic List.

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

Click **Edit** to further edit the topic, or click **Clear All** to clear all topic information you entered. Click **Begin** to start the next topic.

Proceed to the Meaningful Use Clinical Quality Measures (Stage 1 and Stage 2) on page 152.



Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 2
Program Year 2014

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Attestation Meaningful Use Measures

Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.

Available actions for a topic will be determined by current progress level. To start a topic, select the **"Begin"** button. To modify a topic where entries have been made, select the **"EDIT"** button for a topic to modify any previously entered information. Select **"Previous"** to return.

Completed?	Topics	Progress	Action
✓	General Requirements	2/2	EDIT Clear All
✓	Core Measures	17/17	EDIT Clear All
✓	Menu Measures	4/4	EDIT Clear All

Please select one of the following three Clinical Quality Measure set options.

Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the **"Clear All"** button on the previously selected CQM set to enable the **"Begin"** button on a different CQM set. *Please note that the previously entered information will be cleared once the **"Clear All"** button is selected.*

Clinical Quality Measure - General	Begin
Clinical Quality Measure - Adult Set	Begin
Clinical Quality Measure - Pediatric Set	Begin

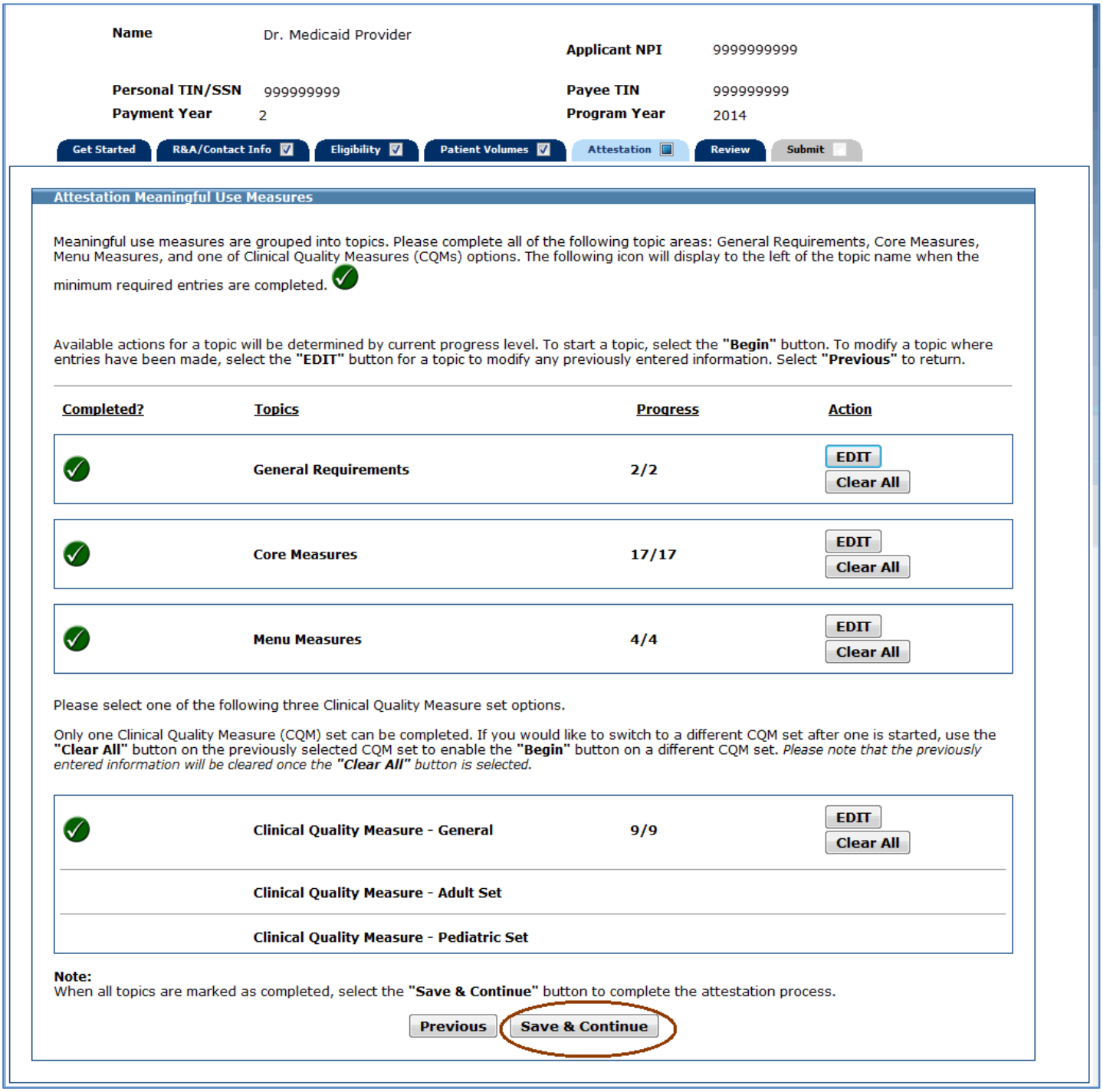
Note:
When all topics are marked as completed, select the **"Save & Continue"** button to complete the attestation process.

Previous Save & Continue

Meaningful Use Measures Summary for Stage 2

This screen displays the Measures Topic List for **Stage 2** with all four Meaningful Use Measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.

Proceed to the Meaningful Use Measures Summary screen on the following page.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
2
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
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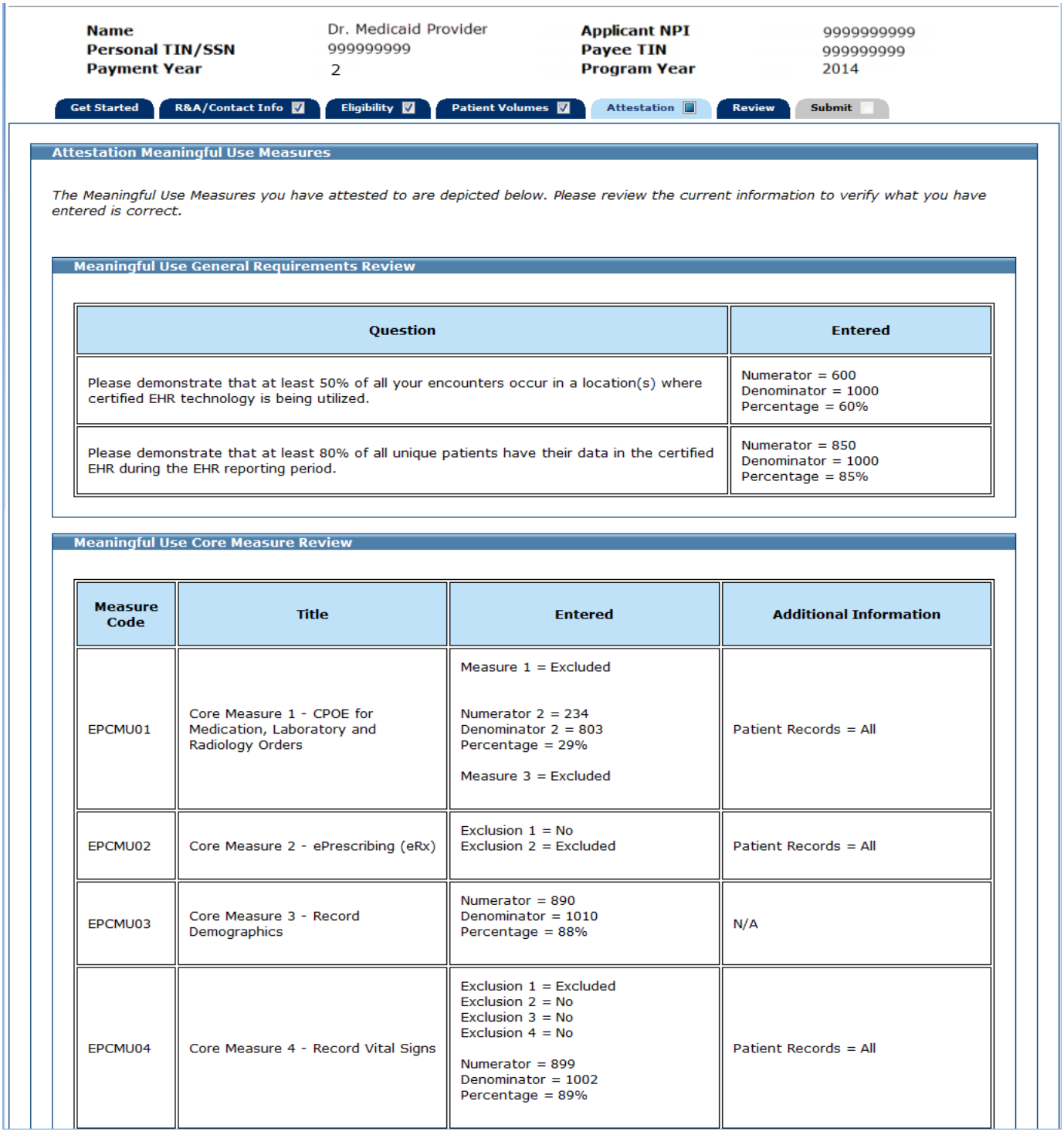
Attestation Meaningful Use Measures
Meaningful use measures are grouped into topics. Please complete all of the following topic areas: General Requirements, Core Measures, Menu Measures, and one of Clinical Quality Measures (CQMs) options. The following icon will display to the left of the topic name when the minimum required entries are completed.
Available actions for a topic will be determined by current progress level. To start a topic, select the "Begin" button. To modify a topic where entries have been made, select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
17/17
EDIT
Clear All
Menu Measures
4/4
EDIT
Clear All
Please select one of the following three Clinical Quality Measure set options.
Only one Clinical Quality Measure (CQM) set can be completed. If you would like to switch to a different CQM set after one is started, use the "Clear All" button on the previously selected CQM set to enable the "Begin" button on a different CQM set. Please note that the previously entered information will be cleared once the "Clear All" button is selected.
Clinical Quality Measure - General
9/9
EDIT
Clear All
Clinical Quality Measure - Adult Set
Clinical Quality Measure - Pediatric Set
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click **Previous** to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click **Save & Continue** to proceed to Part 3 of 3 of the Attestation Phase.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
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Attestation Meaningful Use Measures

The Meaningful Use Measures you have attested to are depicted below. Please review the current information to verify what you have entered is correct.

Meaningful Use General Requirements Review

Question	Entered
Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.	Numerator = 600 Denominator = 1000 Percentage = 60%
Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.	Numerator = 850 Denominator = 1000 Percentage = 85%

Meaningful Use Core Measure Review

Measure Code	Title	Entered	Additional Information
EPCMU01	Core Measure 1 - CPOE for Medication, Laboratory and Radiology Orders	Measure 1 = Excluded Numerator 2 = 234 Denominator 2 = 803 Percentage = 29% Measure 3 = Excluded	Patient Records = All
EPCMU02	Core Measure 2 - ePrescribing (eRx)	Exclusion 1 = No Exclusion 2 = Excluded	Patient Records = All
EPCMU03	Core Measure 3 - Record Demographics	Numerator = 890 Denominator = 1010 Percentage = 88%	N/A
EPCMU04	Core Measure 4 - Record Vital Signs	Exclusion 1 = Excluded Exclusion 2 = No Exclusion 3 = No Exclusion 4 = No Numerator = 899 Denominator = 1002 Percentage = 89%	Patient Records = All

This is screen 2 of 4 of the Meaningful Use Measure Review.

EPCMU05	Core Measure 5 - Record Smoking Status	Exclusion = No Numerator = 87 Denominator = 105 Percentage = 82%	Patient Records = All
EPCMU06	Core Measure 6 - Clinical Decision Support Rule	Measure 1 = Yes Measure 2 Exclusion = No Measure 2 = Yes	N/A
EPCMU07	Core Measure 7 - Patient Electronic Access	Exclusion Measure 1 and 2 = Excluded	N/A
EPCMU08	Core Measure 8 - Clinical Summaries	Exclusion = No Numerator = 654 Denominator = 1045 Percentage = 62%	Patient Records = All
EPCMU09	Core Measure 9 - Protect Electronic Health Information	Yes	N/A
EPCMU10	Core Measure 10 - Clinical Lab - Test Results	Exclusion = Excluded	Patient Records = All
EPCMU11	Core Measure 11 - Patient Lists	Yes	N/A
EPCMU12	Core Measure 12 - Preventive Care	Exclusion = No Numerator = 176 Denominator = 897 Percentage = 19%	Patient Records = All
EPCMU13	Core Measure 13 - Patient-Specific Education Resources	Exclusion = Excluded	Patient Records = All
EPCMU14	Core Measure 14 - Medication Reconciliation	Exclusion = No Numerator = 687 Denominator = 1056 Percentage = 65%	N/A
EPCMU15	Core Measure 15 - Summary of Care	Exclusion = No Numerator 1 = 80 Denominator 1 = 100 Percentage = 80% Numerator 2 = 87 Denominator 2 = 107 Percentage = 81% Measure 3 = Satisfied a = Yes Satisfied b = Yes	N/A
EPCMU16	Core Measure 16 - Immunization Registries Data Submission	Q1 = Yes Q2 = Yes Q3 = Yes Q4 = Yes	N/A
EPCMU17	Core Measure 17 - Use Secure Electronic Messaging	Exclusion = No Numerator = 58 Denominator = 200 Percentage = 29%	N/A

This is screen 3 of 4 of the Meaningful Use Measure Review.

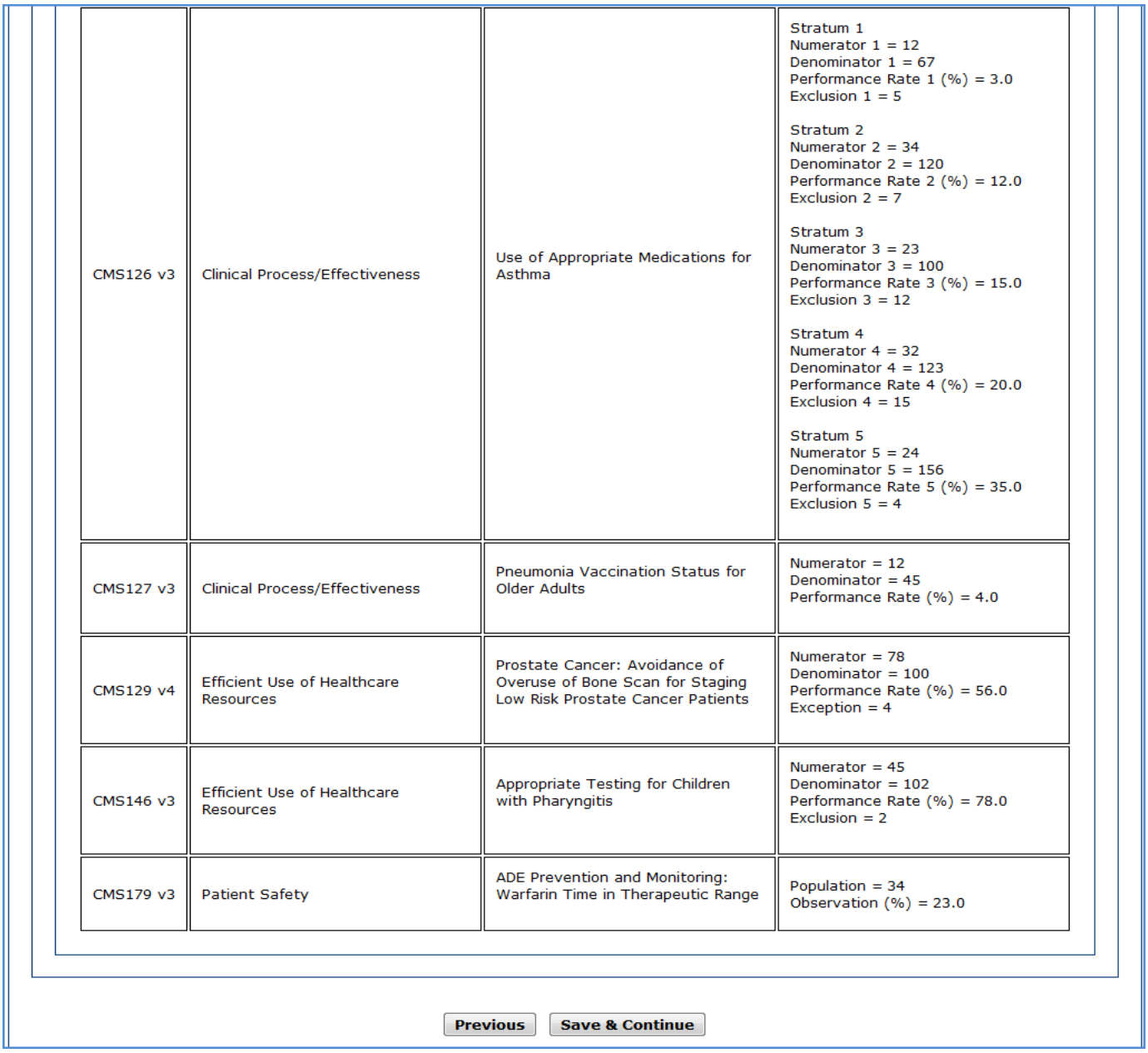
Meaningful Use Menu Measure Review

Measure Code	Title	Entered	Additional Information
EPMMU01	Menu Measure 1 - Syndromic Surveillance Data Submission	Q1 = Yes Q2 = No Q3 = Yes Q4 = No	N/A
EPMMU02	Menu Measure 2 - Electronic Notes	Numerator = 304 Denominator = 998 Percentage = 30%	N/A
EPMMU03	Menu Measure 3 - Imaging Results	Excluded	N/A
EPMMU04	Menu Measure 4 - Family Health History	Numerator = 345 Denominator = 1010 Percentage = 34%	N/A

Meaningful Use Clinical Quality Measure Review

Measure Code	Domain	Title	Entered
CMS50 v3	Care Coordination	Closing the referral loop: receipt of specialist report	Numerator = 25 Denominator = 100 Performance Rate (%) = 10.0
CMS52 v3	Clinical Process/Effectiveness	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Stratum 1 Numerator 1 = 34 Denominator 1 = 100 Performance Rate 1 (%) = 13.0 Exception 1 = 3 Stratum 2 Numerator 2 = 45 Denominator 2 = 123 Performance Rate 2 (%) = 12.0 Exception 2 = 5 Stratum 3 Numerator 3 = 45 Denominator 3 = 100 Performance Rate 3 (%) = 4.0
CMS61 v4	Clinical Process/Effectiveness	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Stratum 1 Numerator 1 = 23 Denominator 1 = 102 Performance Rate 1 (%) = 2.0 Exclusion 1 = 4 Exception 1 = 12 Stratum 2 Numerator 2 = 34 Denominator 2 = 105 Performance Rate 2 (%) = 3.0 Exclusion 2 = 5 Exception 2 = 12 Stratum 3 Numerator 3 = 54 Denominator 3 = 100 Performance Rate 3 (%) = 10.0 Exclusion 3 = 7 Exception 3 = 14
CMS125 v3	Clinical Process/Effectiveness	Breast Cancer Screening	Numerator = 23 Denominator = 101 Performance Rate (%) = 4.0 Exclusion = 5

This is screen 4 of 4 of the Meaningful Use Measure Review.



CMS126 v3	Clinical Process/Effectiveness	Use of Appropriate Medications for Asthma	Stratum 1 Numerator 1 = 12 Denominator 1 = 67 Performance Rate 1 (%) = 3.0 Exclusion 1 = 5 Stratum 2 Numerator 2 = 34 Denominator 2 = 120 Performance Rate 2 (%) = 12.0 Exclusion 2 = 7 Stratum 3 Numerator 3 = 23 Denominator 3 = 100 Performance Rate 3 (%) = 15.0 Exclusion 3 = 12 Stratum 4 Numerator 4 = 32 Denominator 4 = 123 Performance Rate 4 (%) = 20.0 Exclusion 4 = 15 Stratum 5 Numerator 5 = 24 Denominator 5 = 156 Performance Rate 5 (%) = 35.0 Exclusion 5 = 4
CMS127 v3	Clinical Process/Effectiveness	Pneumonia Vaccination Status for Older Adults	Numerator = 12 Denominator = 45 Performance Rate (%) = 4.0
CMS129 v4	Efficient Use of Healthcare Resources	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Numerator = 78 Denominator = 100 Performance Rate (%) = 56.0 Exception = 4
CMS146 v3	Efficient Use of Healthcare Resources	Appropriate Testing for Children with Pharyngitis	Numerator = 45 Denominator = 102 Performance Rate (%) = 78.0 Exclusion = 2
CMS179 v3	Patient Safety	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Population = 34 Observation (%) = 23.0

Previous Save & Continue

Proceed to the Attestation Phase (Part 3 of 3) on page 171.

Stages 1 and 2

Meaningful Use Clinical Quality Measures

There are a total of 64 Meaningful Use Clinical Quality Measures available for you to attest to. To simplify the selection process for EPs with an adult population and EPs with a pediatric population, the Clinical Quality Measures are grouped into sets that contain the recommended measures for these two populations. You may also choose from all 64 measures by selecting the General set. The following are the three available Clinical Quality Measures sets to choose from:

- General: Lists all 64 available Clinical Quality Measures
- Adult Set: Lists the Clinical Quality Measures recommended for EPs with an adult population
- Pediatric Set: Lists the Clinical Quality Measures recommended for EPs with a pediatric population

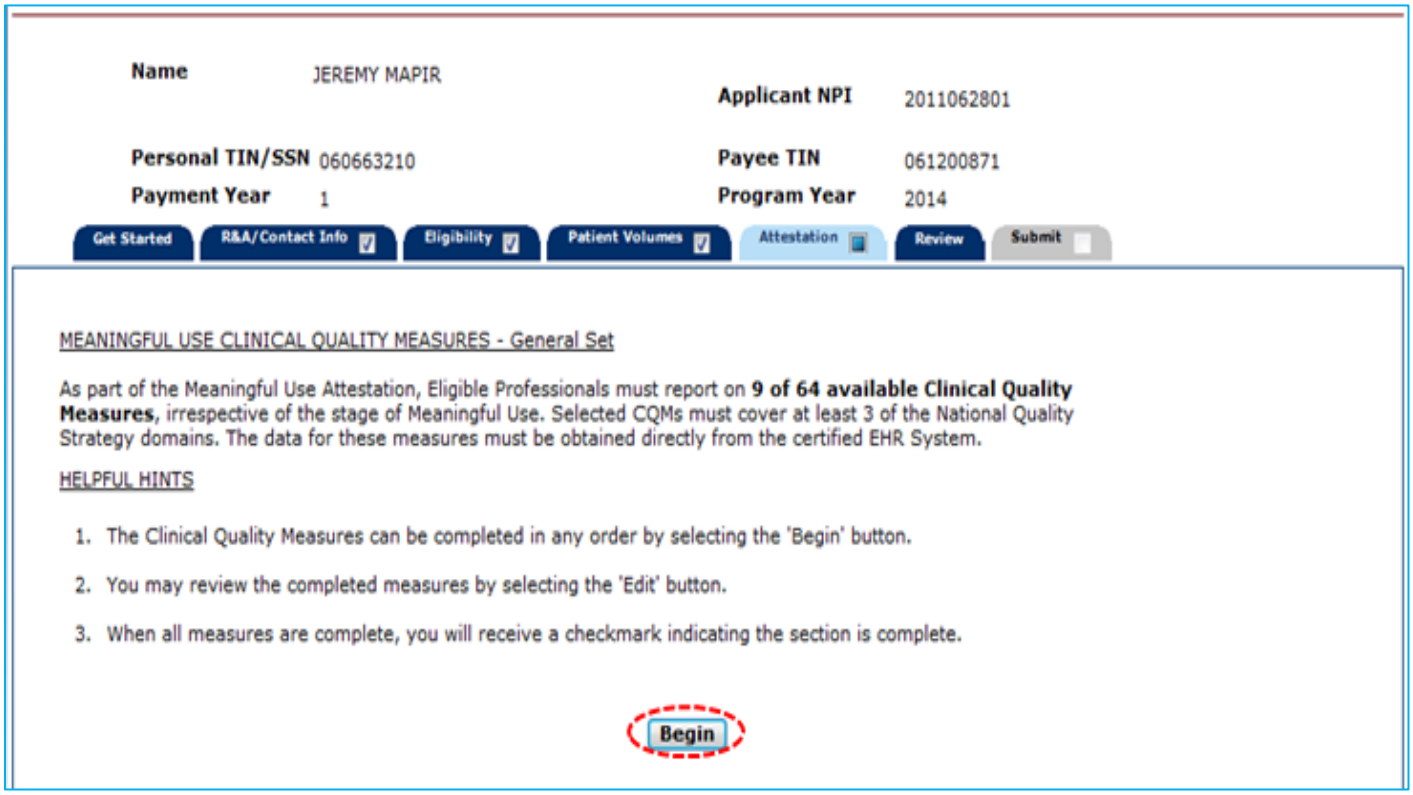
Only one Clinical Quality Measure set can be completed. If you would like to switch to a different set after one is started, select the Clear All button on the previously selected set.

Select the set that you would like to use to pick at least nine Meaningful Use Clinical Quality Measures from.

This initial screen provides information about the Clinical Quality Measure set you selected: General, Adult set, or Pediatric set.

The following screen is an example of the General set.

Click **Begin** to continue to the Meaningful Use Clinical Quality Selection screen.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
060663210
Payee TIN
061200871
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
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Submit
MEANINGFUL USE CLINICAL QUALITY MEASURES - General Set
As part of the Meaningful Use Attestation, Eligible Professionals must report on 9 of 64 available Clinical Quality Measures, irrespective of the stage of Meaningful Use. Selected CQMs must cover at least 3 of the National Quality Strategy domains. The data for these measures must be obtained directly from the certified EHR System.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. You may review the completed measures by selecting the 'Edit' button.
3. When all measures are complete, you will receive a checkmark indicating the section is complete.
Begin

The following screen is an example of the Adult set.

Click **Begin** to continue to the Meaningful Use Clinical Quality Selection screen.

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
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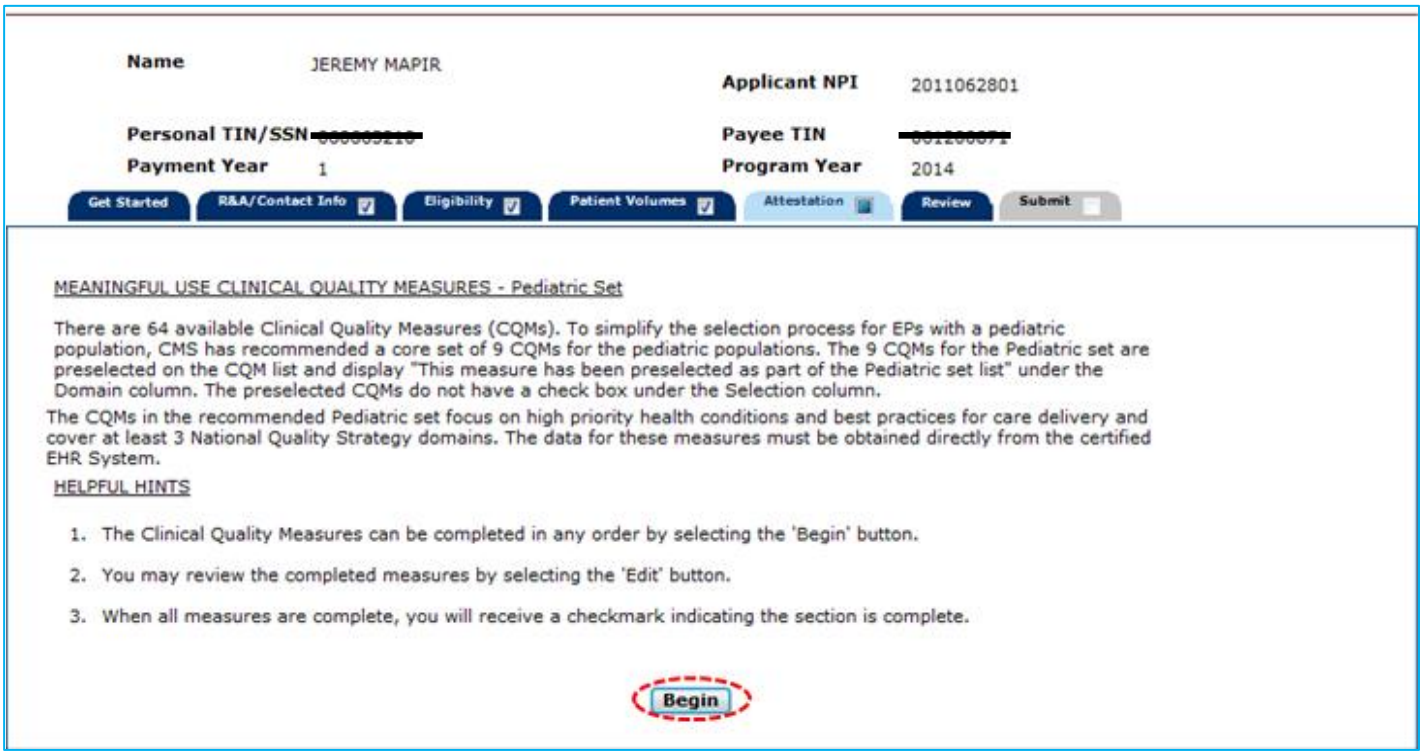
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE CLINICAL QUALITY MEASURES - Adult Set
There are 64 available Clinical Quality Measures (CQMs). To simplify the selection process for EPs with an adult population, CMS has recommended a core set of 9 CQMs for the adult populations. The 9 CQMs for the Adult set are preselected on the CQM list and display "This measure has been preselected as part of the Adult set list" under the Domain column. The preselected CQMs do not have a check box under the Selection column.
The CQMs in the recommended Adult set focus on high priority health conditions and best practices for care delivery and cover at least 3 National Quality Strategy domains. The data for these measures must be obtained directly from the certified EHR System.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. You may review the completed measures by selecting the 'Edit' button.
3. When all measures are complete, you will receive a checkmark indicating the section is complete.
Begin

The following screen is an example of the Pediatric set.

Click **Begin** to continue to the Meaningful Use Clinical Quality Selection screen.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE CLINICAL QUALITY MEASURES - Pediatric Set
There are 64 available Clinical Quality Measures (CQMs). To simplify the selection process for EPs with a pediatric population, CMS has recommended a core set of 9 CQMs for the pediatric populations. The 9 CQMs for the Pediatric set are preselected on the CQM list and display "This measure has been preselected as part of the Pediatric set list" under the Domain column. The preselected CQMs do not have a check box under the Selection column.
The CQMs in the recommended Pediatric set focus on high priority health conditions and best practices for care delivery and cover at least 3 National Quality Strategy domains. The data for these measures must be obtained directly from the certified EHR System.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. You may review the completed measures by selecting the 'Edit' button.
3. When all measures are complete, you will receive a checkmark indicating the section is complete.
Begin

The screens on the following pages display the Meaningful Use Clinical Quality Selection screen for the set you selected. In this example, the General set was selected.

Each Clinical Quality Measure is associated to one of the six domains.

Select a minimum of nine Meaningful Use Clinical Quality Measures from at least three different domains.

Click **Save & Continue** to proceed, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.

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Payment Year	1	**Program Year**	2014

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Attestation Meaningful Use Measures

Meaningful Use Clinical Quality Measure Worklist Table

You have chosen the general Clinical Quality Measure (CQM) set. Select a minimum of nine (9) CQMs from at least three (3) different domains. There are six (6) domains and sixty-four (64) CQMs from which to choose. The domain of each CQM is shown in the title bar of each individual CQM. If you wish to select the adult recommended CQMs or the pediatric recommended CQMs select the **"Return to Main"** button and then choose the recommended CQM option you wish to answer. Please note, as a minimum you must select nine (9) CQMs from three (3) different domains before proceeding to the next screen.

If you do not want to complete these nine measures then select the **"Return to Main"** button below and use the **"Clear All"** button on the previously selected Clinical Quality Measure General set line to enable the **"Begin"** button on a different CQM set. The previously entered information will be cleared once the **"Clear All"** button is selected.

Please Note: Clinical quality measures are sorted by Domain category and then by Measure Number.

Clinical Quality Measure list Table

Measure#	Title	Domain	Selection
CMS50 v3	Closing the referral loop: receipt of specialist report	Care Coordination	☑
CMS52 v3	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness	☑
CMS61 v4	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Clinical Process/Effectiveness	☑
CMS62 v3	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness	☐
CMS64 v4	Preventive Care and Screening: Risk-Stratified Cholesterol - Fasting Low Density Lipoprotein (LDL-C)	Clinical Process/Effectiveness	☐
CMS65 v4	Hypertension: Improvement in blood pressure	Clinical Process/Effectiveness	☑
CMS74 v4	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Clinical Process/Effectiveness	☐
CMS75 v3	Children who have dental decay or cavities	Clinical Process/Effectiveness	☐
CMS77 v3	HIV/AIDS: RNA control for Patients with HIV	Clinical Process/Effectiveness	☐
CMS122 v3	Diabetes: Hemoglobin A1c Poor Control	Clinical Process/Effectiveness	☐
CMS123 v3	Diabetes: Foot Exam	Clinical Process/Effectiveness	☐
CMS124 v3	Cervical Cancer Screening	Clinical Process/Effectiveness	☐
CMS125 v3	Breast Cancer Screening	Clinical Process/Effectiveness	☑
CMS126 v3	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness	☑
CMS127 v3	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness	☑
CMS128 v3	Anti-depressant Medication Management	Clinical Process/Effectiveness	☐
CMS130 v3	Colorectal Cancer Screening	Clinical Process/Effectiveness	☐
CMS131 v3	Diabetes: Eye Exam	Clinical Process/Effectiveness	☐
CMS133 v3	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Clinical Process/Effectiveness	☐
CMS134 v3	Diabetes: Urine Protein Screening	Clinical Process/Effectiveness	☐
CMS135 v3	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness	☐
CMS136 v4	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Clinical Process/Effectiveness	☐
CMS137 v3	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/Effectiveness	☐
CMS140 v3	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Clinical Process/Effectiveness	☐
CMS141 v4	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Clinical Process/Effectiveness	☐
CMS142 v3	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Clinical Process/Effectiveness	☐

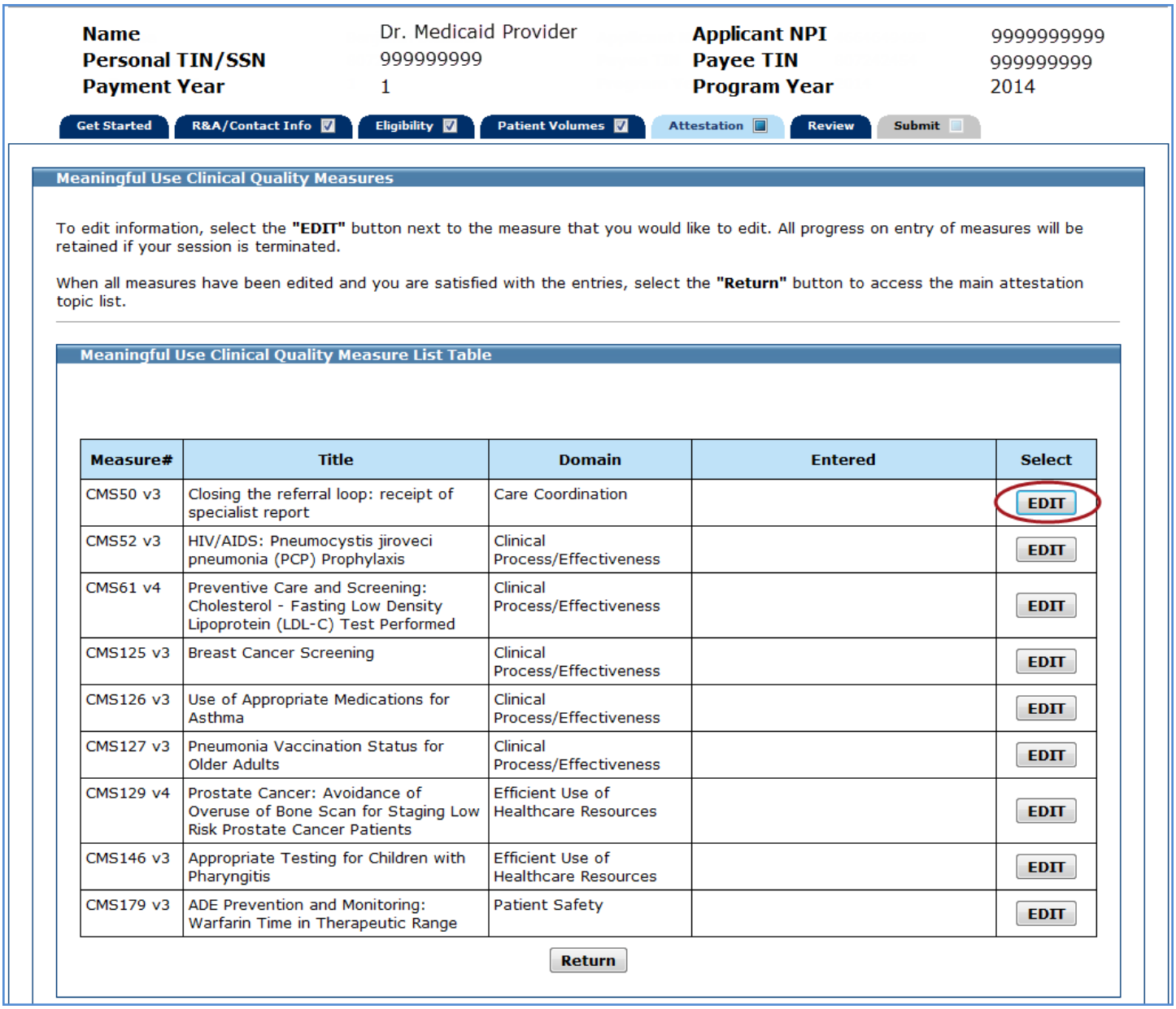
CMS143 v3	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Clinical Process/Effectiveness	☐
CMS144 v3	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness	☐
CMS145 v3	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)	Clinical Process/Effectiveness	☐
CMS148 v3	Hemoglobin A1c Test for Pediatric Patients	Clinical Process/Effectiveness	☐
CMS149 v3	Dementia: Cognitive Assessment	Clinical Process/Effectiveness	☐
CMS158 v3	Pregnant women that had HBsAg testing	Clinical Process/Effectiveness	☐
CMS159 v3	Depression Remission at Twelve Months	Clinical Process/Effectiveness	☐
CMS160 v3	Depression Utilization of the PHQ-9 Tool	Clinical Process/Effectiveness	☐
CMS161 v3	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinical Process/Effectiveness	☐
CMS163 v3	Diabetes: Low Density Lipoprotein (LDL) Management	Clinical Process/Effectiveness	☐
CMS164 v3	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Clinical Process/Effectiveness	☐
CMS165 v3	Controlling High Blood Pressure	Clinical Process/Effectiveness	☐
CMS167 v3	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Clinical Process/Effectiveness	☐
CMS169 v3	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Clinical Process/Effectiveness	☐
CMS182 v4	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Clinical Process/Effectiveness	☐
CMS129 v4	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficient Use of Healthcare Resources	☑
CMS146 v3	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources	☑
CMS154 v3	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficient Use of Healthcare Resources	☐
CMS166 v4	Use of Imaging Studies for Low Back Pain	Efficient Use of Healthcare Resources	☐
CMS56 v3	Functional status assessment for hip replacement	Patient and Family Engagement	☐
CMS66 v3	Functional status assessment for knee replacement	Patient and Family Engagement	☐
CMS90 v4	Functional status assessment for complex chronic conditions	Patient and Family Engagement	☐
CMS157 v3	Oncology: Medical and Radiation - Pain Intensity Quantified	Patient and Family Engagement	☐
CMS68 v4	Documentation of Current Medications in the Medical Record	Patient Safety	☐
CMS132 v3	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Patient Safety	☐
CMS139 v3	Falls: Screening for Future Fall Risk	Patient Safety	☐
CMS156 v3	Use of High-Risk Medications in the Elderly	Patient Safety	☐
CMS177 v3	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Patient Safety	☐
CMS179 v3	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety	☑
CMS2 v4	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health	☐
CMS22 v3	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Population/Public Health	☐
CMS69 v3	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Population/Public Health	☐
CMS82 v2	Maternal depression screening	Population/Public Health	☐
CMS117 v3	Childhood Immunization Status	Population/Public Health	☐
CMS138 v3	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health	☐
CMS147 v3	Preventive Care and Screening: Influenza Immunization	Population/Public Health	☐
CMS153 v3	Chlamydia Screening for Women	Population/Public Health	☐
CMS155 v3	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health	☐

Return to Main Reset Save & Continue

The screen below displays the Meaningful Use Clinical Quality Measure Worklist Table. This screen displays the Meaningful Use Clinical Quality Measures you selected on the previous screen.

Click **Edit** to enter or edit information for the measure, or click **Return** to return to the Meaningful Use Clinical Quality Selection screen.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999
Personal TIN/SSN 999999999 **Payee TIN** 999999999
Payment Year 1 **Program Year** 2014

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Meaningful Use Clinical Quality Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

Meaningful Use Clinical Quality Measure List Table

Measure#	Title	Domain	Entered	Select
CMS50 v3	Closing the referral loop: receipt of specialist report	Care Coordination		EDIT
CMS52 v3	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness		EDIT
CMS61 v4	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Clinical Process/Effectiveness		EDIT
CMS125 v3	Breast Cancer Screening	Clinical Process/Effectiveness		EDIT
CMS126 v3	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness		EDIT
CMS127 v3	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness		EDIT
CMS129 v4	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficient Use of Healthcare Resources		EDIT
CMS146 v3	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources		EDIT
CMS179 v3	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety		EDIT

Return

The following is a list of the 64 Clinical Quality Measures available for you to attest to:

Measure Number	Clinical Quality Measure	Domain	Screen Example
CMS137v3	Clinical Quality Measure 2	Clinical Process/Effectiveness	Screen 2
CMS165v3	Clinical Quality Measure 3		Screen 1
CMS125v3	Clinical Quality Measure 7		Screen 1
CMS124v3	Clinical Quality Measure 8		Screen 1
CMS130v3	Clinical Quality Measure 10		Screen 1
CMS126v3	Clinical Quality Measure 11		Screen 2
CMS127v3	Clinical Quality Measure 14		Screen 3
CMS131v3	Clinical Quality Measure 16		Screen 3
CMS123v3	Clinical Quality Measure 17		Screen 3
CMS122v3	Clinical Quality Measure 18		Screen 3
CMS148v3	Clinical Quality Measure 19		Screen 3
CMS134v3	Clinical Quality Measure 20		Screen 3
CMS163v3	Clinical Quality Measure 21		Screen 3
CMS164v3	Clinical Quality Measure 22		Screen 3
CMS145v3	Clinical Quality Measure 24		Screen 4
CMS182v4	Clinical Quality Measure 25		Screen 3
CMS135v3	Clinical Quality Measure 26		Screen 1
CMS144v3	Clinical Quality Measure 27		Screen 1
CMS143v3	Clinical Quality Measure 28		Screen 1
CMS167v3	Clinical Quality Measure 29		Screen 1
CMS142v3	Clinical Quality Measure 30		Screen 1
CMS161v3	Clinical Quality Measure 32		Screen 3
CMS128v3	Clinical Quality Measure 33		Screen 1
CMS136v3	Clinical Quality Measure 34		Screen 3

Measure Number	Clinical Quality Measure	Domain	Screen Example
CMS169v3	Clinical Quality Measure 35		Screen 3
CMS141v4	Clinical Quality Measure 37		Screen 1
CMS140v3	Clinical Quality Measure 38		Screen 1
CMS62v3	Clinical Quality Measure 40		Screen 3
CMS52v3	Clinical Quality Measure 41		Screen 4
CMS77v3	Clinical Quality Measure 42		Screen 3
CMS133v3	Clinical Quality Measure 47		Screen 1
CMS158v3	Clinical Quality Measure 48		Screen 1
CMS159v3	Clinical Quality Measure 49		Screen 1
CMS160v3	Clinical Quality Measure 50		Screen 4
CMS75v3	Clinical Quality Measure 51		Screen 3
CMS74v4	Clinical Quality Measure 54		Screen 2
CMS61v4	Clinical Quality Measure 55		Screen 4
CMS64v4	Clinical Quality Measure 56		Screen 4
CMS149v3	Clinical Quality Measure 57		Screen 1
CMS65v4	Clinical Quality Measure 58		Screen 1
CMS146v3	Clinical Quality Measure 1	Efficient Use of Healthcare Resources	Screen 1
CMS166v4	Clinical Quality Measure 15		Screen 1
CMS154v3	Clinical Quality Measure 23		Screen 1
CMS129v4	Clinical Quality Measure 39		Screen 1
CMS157v3	Clinical Quality Measure 36	Patient and Family Engagement	Screen 3
CMS66v3	Clinical Quality Measure 60		Screen 1
CMS56v3	Clinical Quality Measure 61		Screen 1
CMS90v3	Clinical Quality Measure 62		Screen 1
CMS156v3	Clinical Quality Measure 4	Patient Safety	Screen 3

Measure Number	Clinical Quality Measure	Domain	Screen Example
CMS139v3	Clinical Quality Measure 31		Screen 1
CMS68v4	Clinical Quality Measure 44		Screen 1
CMS132v3	Clinical Quality Measure 46		Screen 1
CMS177v3	Clinical Quality Measure 52		Screen 3
CMS179v3	Clinical Quality Measure 63		Screen 6
CMS155v3	Clinical Quality Measure 5	Population/Public Health	Screen 2
CMS138v3	Clinical Quality Measure 6		Screen 1
CMS153v3	Clinical Quality Measure 9		Screen 2
CMS117v3	Clinical Quality Measure 12		Screen 3
CMS147v3	Clinical Quality Measure 13		Screen 1
CMS2v4	Clinical Quality Measure 43		Screen 5
CMS69v3	Clinical Quality Measure 45		Screen 4
CMS82v2	Clinical Quality Measure 53		Screen 3
CMS22v3	Clinical Quality Measure 64		Screen 5
CMS50v3	Clinical Quality Measure 59	Care Coordination	Screen 3

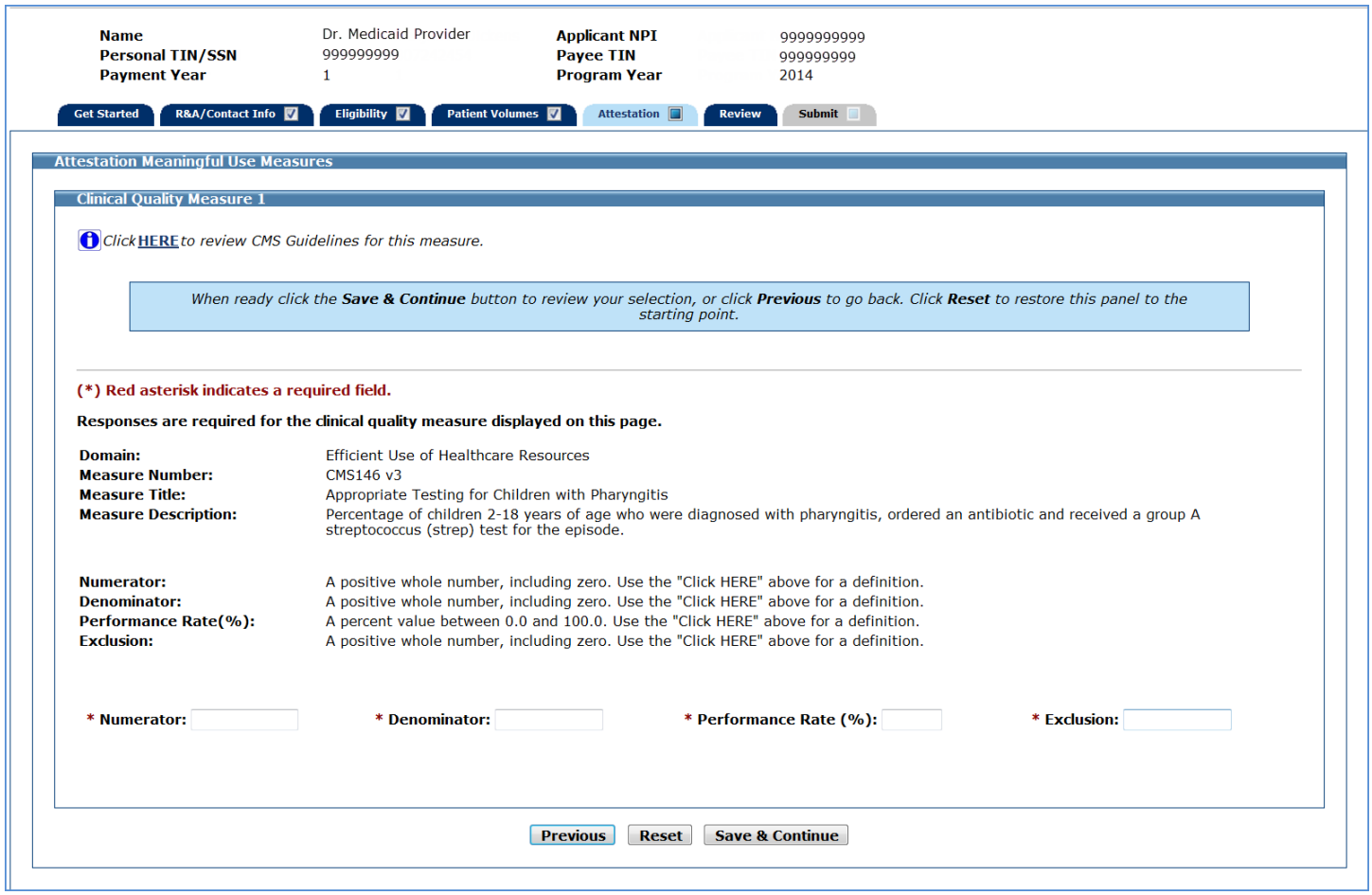
There are 64 Meaningful Use Clinical Quality Measure screens. As you proceed through the Meaningful Use Clinical Quality Measure section of MAPIR, you will see six different screen layouts. Instructions for each measure are provided on the screen. For additional help with a specific Meaningful Use Clinical Quality Measure, click on the link provided above the blue instruction box.

Screen layout examples are shown below.

Screen 1

The following Measure Numbers use this screen layout:

CQM 1, 3, 6, 7, 8, 10, 13, 15, 23, 26, 27, 28, 29, 30, 31, 33, 37, 38, 39, 44, 46, 47, 48, 49, 57, 58, 60, 61, and 62


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
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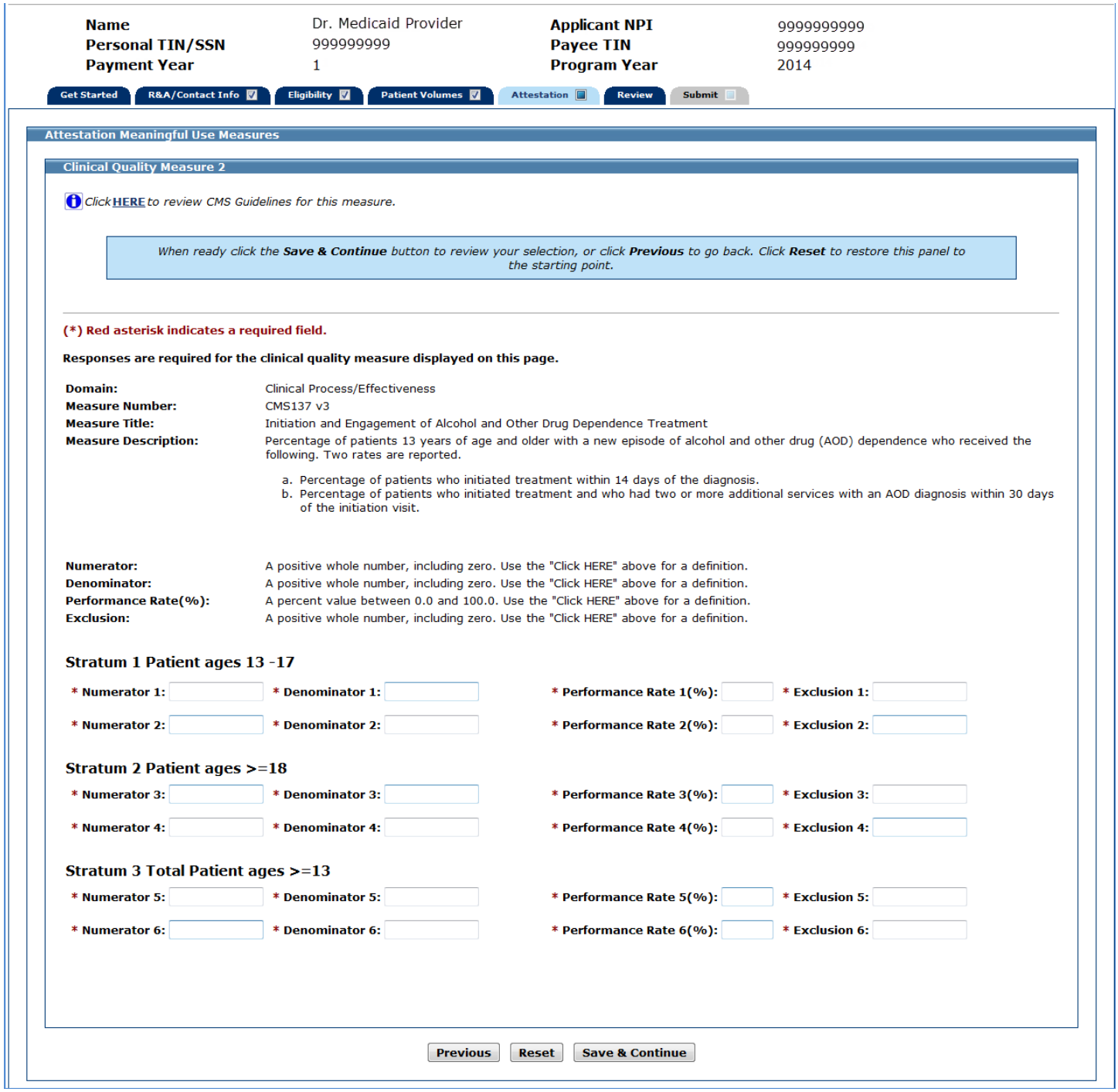
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 1
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Efficient Use of Healthcare Resources
Measure Number:
CMS146 v3
Measure Title:
Appropriate Testing for Children with Pharyngitis
Measure Description:
Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.
Numerator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
* Numerator:
* Denominator:
* Performance Rate (%):
* Exclusion:
Previous
Reset
Save & Continue

Screen 2

The following Measure Numbers use this screen layout:

CQM 2, 5, 9, 11, and 54


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 2
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Clinical Process/Effectiveness
Measure Number:
CMS137 v3
Measure Title:
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure Description:
Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported.
a. Percentage of patients who initiated treatment within 14 days of the diagnosis.
b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Numerator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Stratum 1 Patient ages 13 -17
* Numerator 1:
* Denominator 1:
* Performance Rate 1(%):
* Exclusion 1:
* Numerator 2:
* Denominator 2:
* Performance Rate 2(%):
* Exclusion 2:
Stratum 2 Patient ages >=18
* Numerator 3:
* Denominator 3:
* Performance Rate 3(%):
* Exclusion 3:
* Numerator 4:
* Denominator 4:
* Performance Rate 4(%):
* Exclusion 4:
Stratum 3 Total Patient ages >=13
* Numerator 5:
* Denominator 5:
* Performance Rate 5(%):
* Exclusion 5:
* Numerator 6:
* Denominator 6:
* Performance Rate 6(%):
* Exclusion 6:
Previous
Reset
Save & Continue

Screen 3

The following Measure Numbers use this screen layout:

CQM 4, 12, 14, 16, 17, 18, 19, 20, 21, 22, 25, 32, 34, 35, 36, 40, 42, 51, 52, 53, and 59

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
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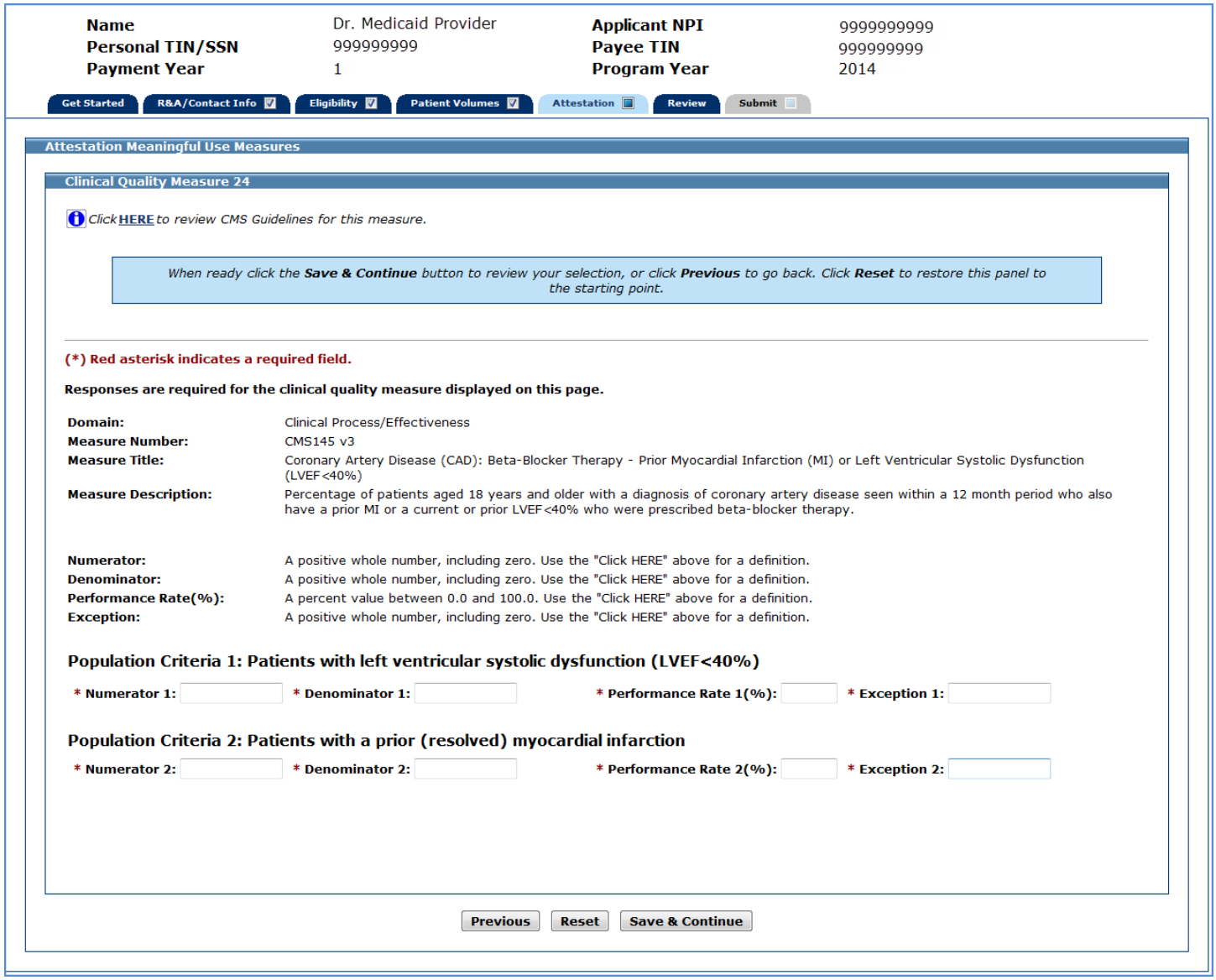
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 12
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Population/Public Health
Measure Number:
CMS117 v3
Measure Title:
Childhood Immunization Status
Measure Description:
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Numerator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
* Numerator:
* Denominator:
* Performance Rate (%):
Previous
Reset
Save & Continue

Screen 4

The following Measure Numbers use this screen layout:

CQM 24, 41, 45, 50, 55, and 56


Name
Dr. Medicaid Provider
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9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
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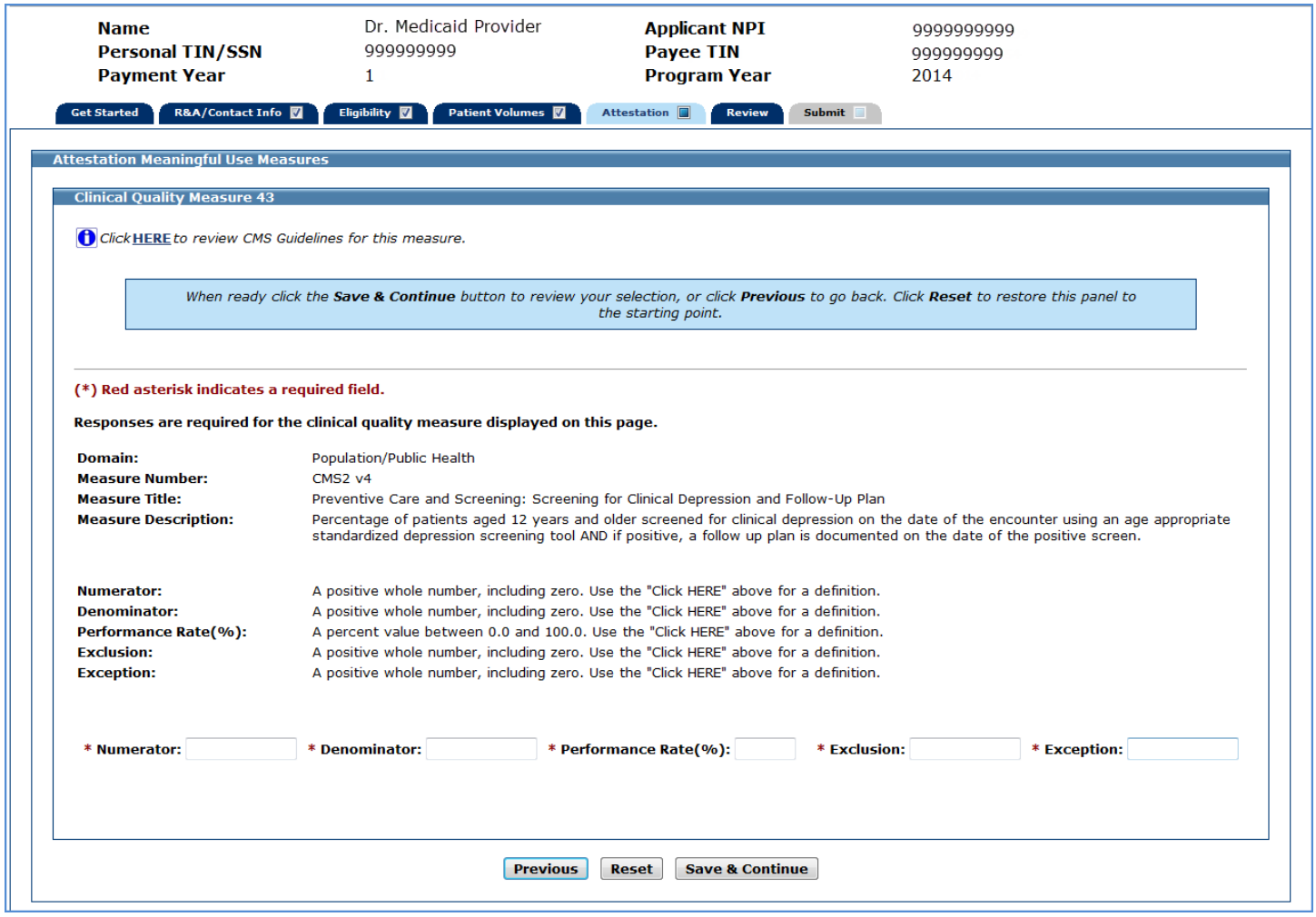
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 24
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Clinical Process/Effectiveness
Measure Number:
CMS145 v3
Measure Title:
Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF<40%)
Measure Description:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF<40% who were prescribed beta-blocker therapy.
Numerator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exception:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Population Criteria 1: Patients with left ventricular systolic dysfunction (LVEF<40%)
* Numerator 1:
* Denominator 1:
* Performance Rate 1(%):
* Exception 1:
Population Criteria 2: Patients with a prior (resolved) myocardial infarction
* Numerator 2:
* Denominator 2:
* Performance Rate 2(%):
* Exception 2:
Previous
Reset
Save & Continue

Screen 5

The following Measure Numbers use this screen layout:

CQM 43 and 64


Name
Dr. Medicaid Provider
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9999999999
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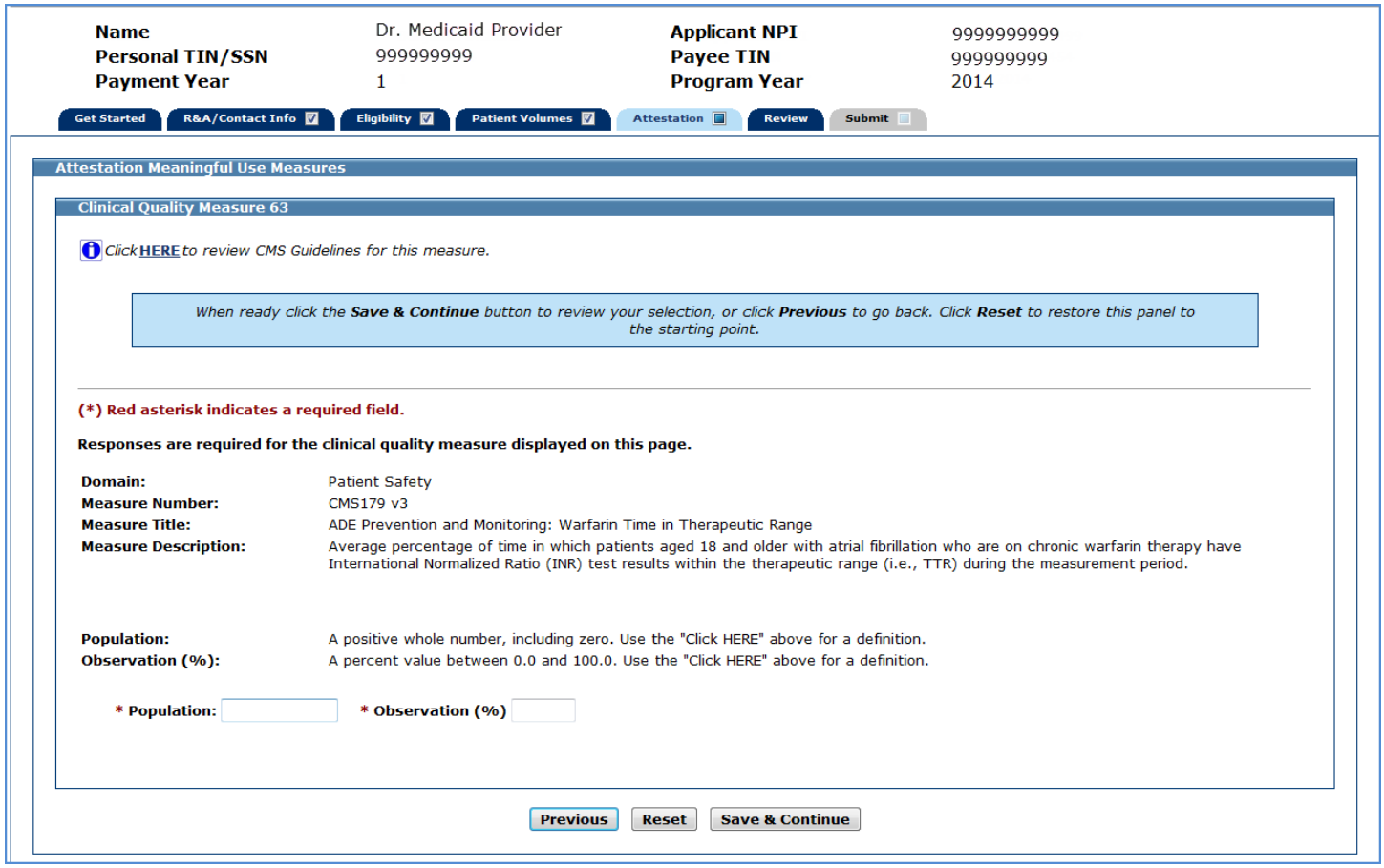
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 43
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Population/Public Health
Measure Number:
CMS2 v4
Measure Title:
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Measure Description:
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.
Numerator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Denominator:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Performance Rate(%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
Exclusion:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Exception:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
* Numerator:
* Denominator:
* Performance Rate(%):
* Exclusion:
* Exception:
Previous
Reset
Save & Continue

Screen 6

The following Measure Numbers use this screen layout:

CQM 63


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
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Program Year
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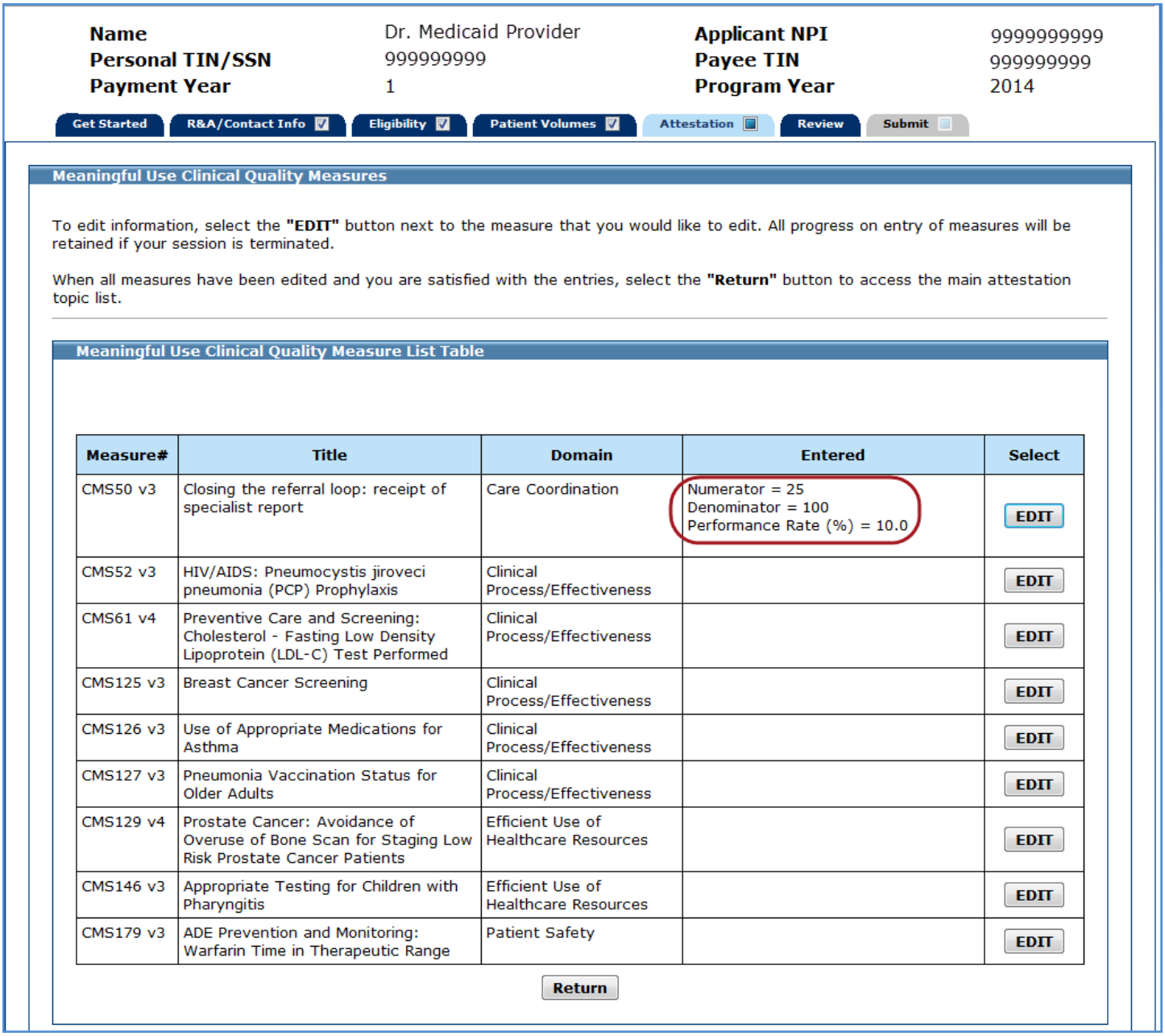
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Clinical Quality Measure 63
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Responses are required for the clinical quality measure displayed on this page.
Domain:
Patient Safety
Measure Number:
CMS179 v3
Measure Title:
ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
Measure Description:
Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.
Population:
A positive whole number, including zero. Use the "Click HERE" above for a definition.
Observation (%):
A percent value between 0.0 and 100.0. Use the "Click HERE" above for a definition.
* Population:
* Observation (%)
Previous
Reset
Save & Continue

After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Clinical Quality Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click **Edit** for the next measure.



Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
Personal TIN/SSN	999999999	**Payee TIN**	999999999
Payment Year	1	**Program Year**	2014

Get Started | R&A/Contact Info ☑ | Eligibility ☑ | Patient Volumes ☑ | Attestation ■ | Review | Submit □

Meaningful Use Clinical Quality Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

Meaningful Use Clinical Quality Measure List Table

Measure#	Title	Domain	Entered	Select
CMS50 v3	Closing the referral loop: receipt of specialist report	Care Coordination	Numerator = 25 Denominator = 100 Performance Rate (%) = 10.0	EDIT
CMS52 v3	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness		EDIT
CMS61 v4	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Clinical Process/Effectiveness		EDIT
CMS125 v3	Breast Cancer Screening	Clinical Process/Effectiveness		EDIT
CMS126 v3	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness		EDIT
CMS127 v3	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness		EDIT
CMS129 v4	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficient Use of Healthcare Resources		EDIT
CMS146 v3	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources		EDIT
CMS179 v3	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety		EDIT

Return

The screens on the following pages display the Meaningful Use Quality Measures List Table with data entered for every measure selected to attest to.

This is screen 1 of 2 of the Meaningful Use Quality Measures List Table.

Name	Dr. Medicaid Provider	**Applicant NPI**	9999999999
Personal TIN/SSN	999999999	**Payee TIN**	999999999
Payment Year	1	**Program Year**	2014

Get Started | R&A/Contact Info ☑ | Eligibility ☑ | Patient Volumes ☑ | Attestation ■ | Review | Submit □

Meaningful Use Clinical Quality Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

Meaningful Use Clinical Quality Measure List Table

Measure#	Title	Domain	Entered	Select
CMS50 v3	Closing the referral loop: receipt of specialist report	Care Coordination	Numerator = 25 Denominator = 100 Performance Rate (%) = 10.0	EDIT
CMS52 v3	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness	Stratum 1 Numerator 1 = 34 Denominator 1 = 100 Performance Rate 1 (%) = 13.0 Exception 1 = 3 Stratum 2 Numerator 2 = 45 Denominator 2 = 123 Performance Rate 2 (%) = 12.0 Exception 2 = 5 Stratum 3 Numerator 3 = 45 Denominator 3 = 100 Performance Rate 3 (%) = 4.0	EDIT
CMS61 v4	Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed	Clinical Process/Effectiveness	Stratum 1 Numerator 1 = 23 Denominator 1 = 102 Performance Rate 1 (%) = 2.0 Exclusion 1 = 4 Exception 1 = 12 Stratum 2 Numerator 2 = 34 Denominator 2 = 105 Performance Rate 2 (%) = 3.0 Exclusion 2 = 5 Exception 2 = 12 Stratum 3 Numerator 3 = 54 Denominator 3 = 100 Performance Rate 3 (%) = 10.0 Exclusion 3 = 7 Exception 3 = 14	EDIT

This is screen 2 of 2 of the Meaningful Use Quality Measures List Table.

CMS125 v3	Breast Cancer Screening	Clinical Process/Effectiveness	Numerator = 23 Denominator = 101 Performance Rate (%) = 4.0 Exclusion = 5	EDIT
CMS126 v3	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness	Stratum 1 Numerator 1 = 12 Denominator 1 = 67 Performance Rate 1 (%) = 3.0 Exclusion 1 = 5 Stratum 2 Numerator 2 = 34 Denominator 2 = 120 Performance Rate 2 (%) = 12.0 Exclusion 2 = 7 Stratum 3 Numerator 3 = 23 Denominator 3 = 100 Performance Rate 3 (%) = 15.0 Exclusion 3 = 12 Stratum 4 Numerator 4 = 32 Denominator 4 = 123 Performance Rate 4 (%) = 20.0 Exclusion 4 = 15 Stratum 5 Numerator 5 = 24 Denominator 5 = 156 Performance Rate 5 (%) = 35.0 Exclusion 5 = 4	EDIT
CMS127 v3	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness	Numerator = 12 Denominator = 45 Performance Rate (%) = 4.0	EDIT
CMS129 v4	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficient Use of Healthcare Resources	Numerator = 78 Denominator = 100 Performance Rate (%) = 56.0 Exception = 4	EDIT
CMS146 v3	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources	Numerator = 45 Denominator = 102 Performance Rate (%) = 78.0 Exclusion = 2	EDIT
CMS179 v3	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Patient Safety	Population = 34 Observation (%) = 23.0	EDIT

Return

Click **Return** to return to the Meaningful Use Clinical Quality Selection screen.

From the Meaningful Use Clinical Quality Selection screen, click **Return to Main** to return to the Measure Topic List.

If you are in Stage 1, proceed to page 112.

If you are in Stage 2, proceed to page 147.

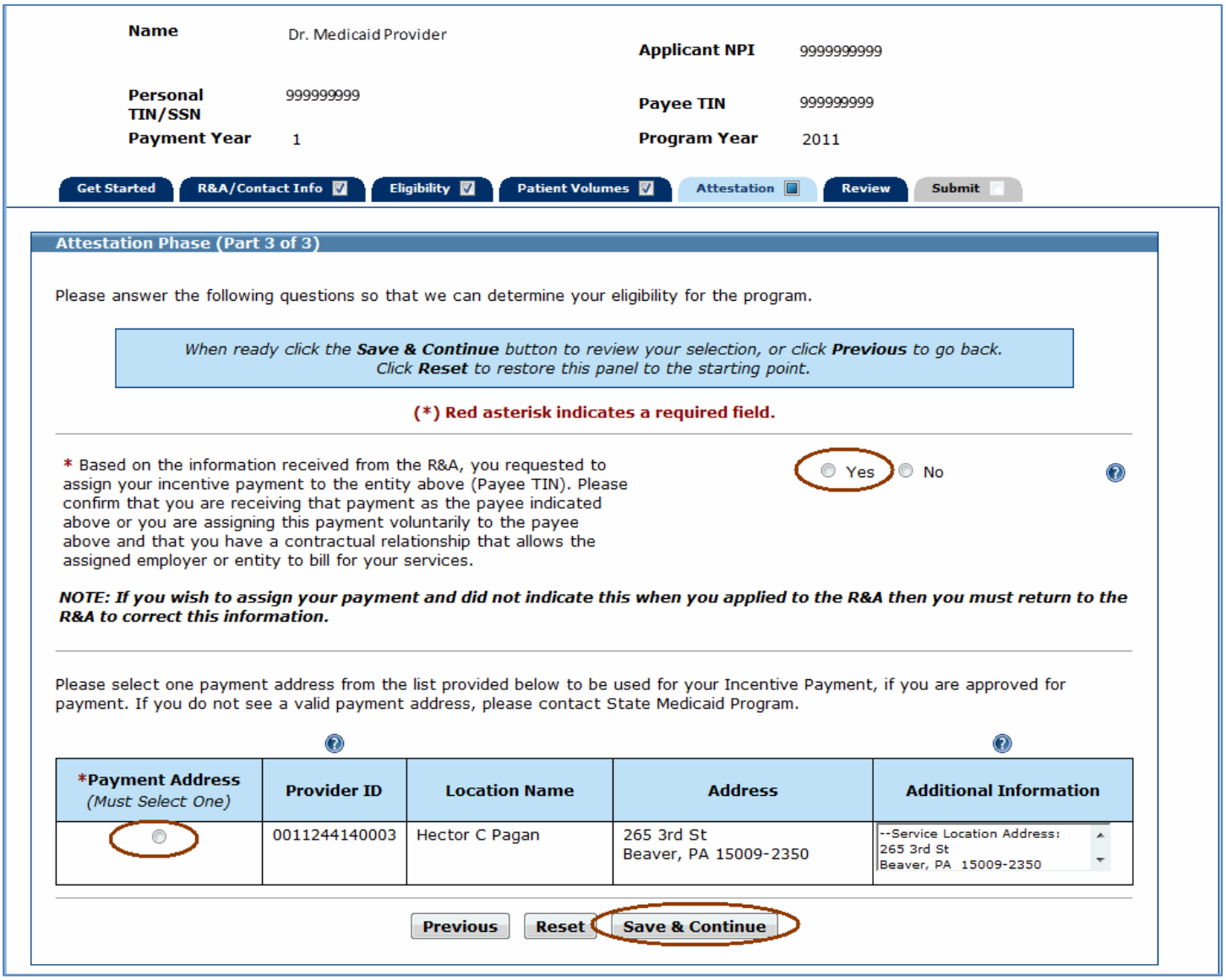
Attestation Phase (Part 3 of 3)

Part 3 of 3 of the Attestation Phase contains a question regarding assignment of your incentive payment and confirmation of the address to which the incentive payment will be sent.

Click **Yes** to confirm you are receiving this payment as the payee indicated or you are assigning this payment voluntarily to the payee and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.

Click the **Payment Address** from the list below to be used for your Incentive Payment.

Click **Save & Continue** to review your selections, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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Payee TIN
999999999
Payment Year
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Program Year
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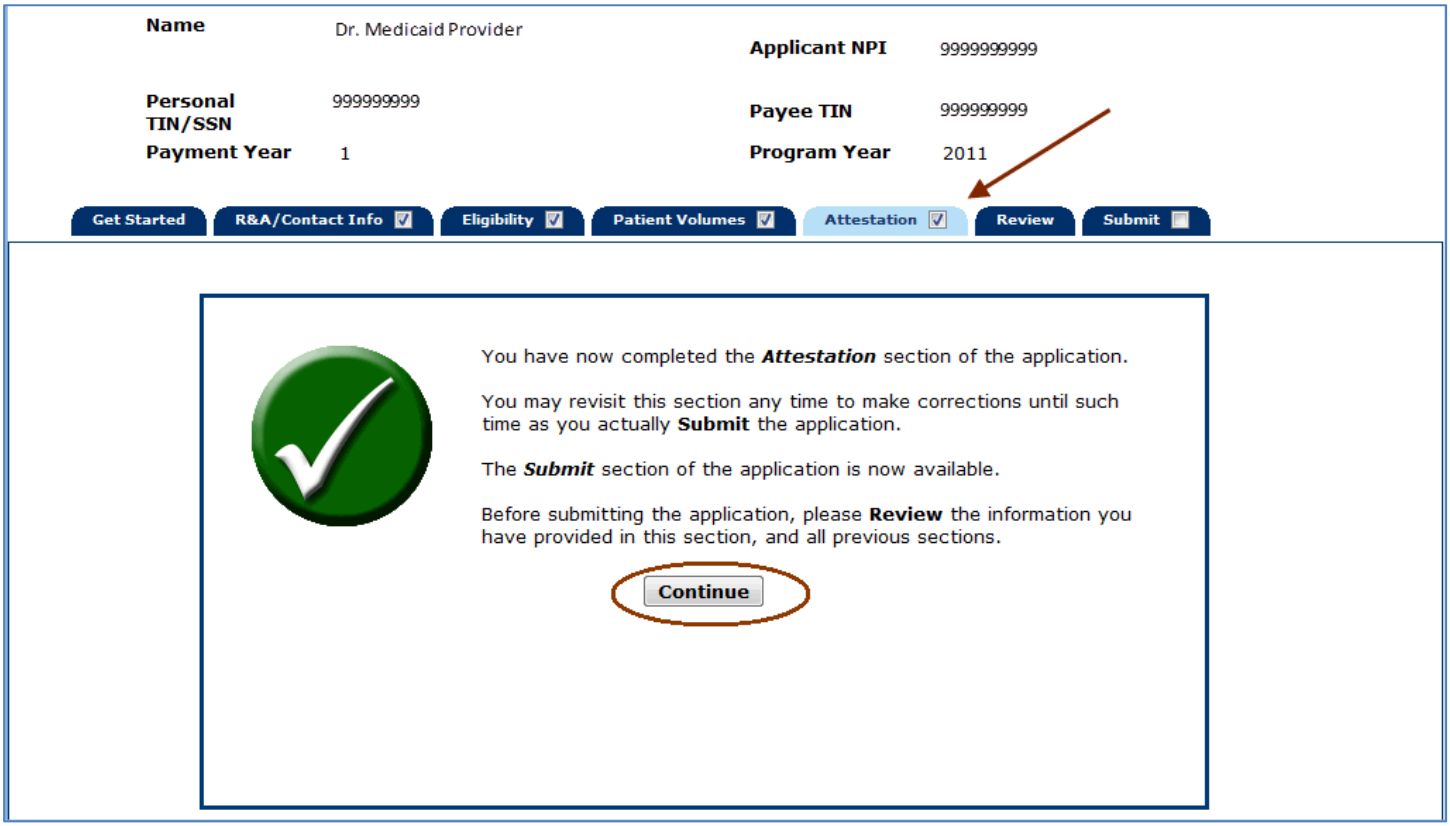
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 3 of 3)
Please answer the following questions so that we can determine your eligibility for the program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Based on the information received from the R&A, you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are receiving that payment as the payee indicated above or you are assigning this payment voluntarily to the payee above and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.
Yes
No
NOTE: If you wish to assign your payment and did not indicate this when you applied to the R&A then you must return to the R&A to correct this information.
Please select one payment address from the list provided below to be used for your Incentive Payment, if you are approved for payment. If you do not see a valid payment address, please contact State Medicaid Program.
*Payment Address (Must Select One)
Provider ID
Location Name
Address
Additional Information
0011244140003
Hector C Pagan
265 3rd St
Beaver, PA 15009-2350
--Service Location Address:
265 3rd St
Beaver, PA 15009-2350
Previous
Reset
Save & Continue

This screen confirms you successfully completed the **Attestation** section.

Note the check box in the Attestation tab.

Click **Continue** to proceed to the **Review** tab.



Step 6 – Review Application

The Review section allows you to review all information you entered into your application. If you find errors you can click the associated tab and proceed to correct the information. Once you have corrected the information you can click the **Review** tab to return to this section. From this screen you can print a printer-friendly copy of your application for review.

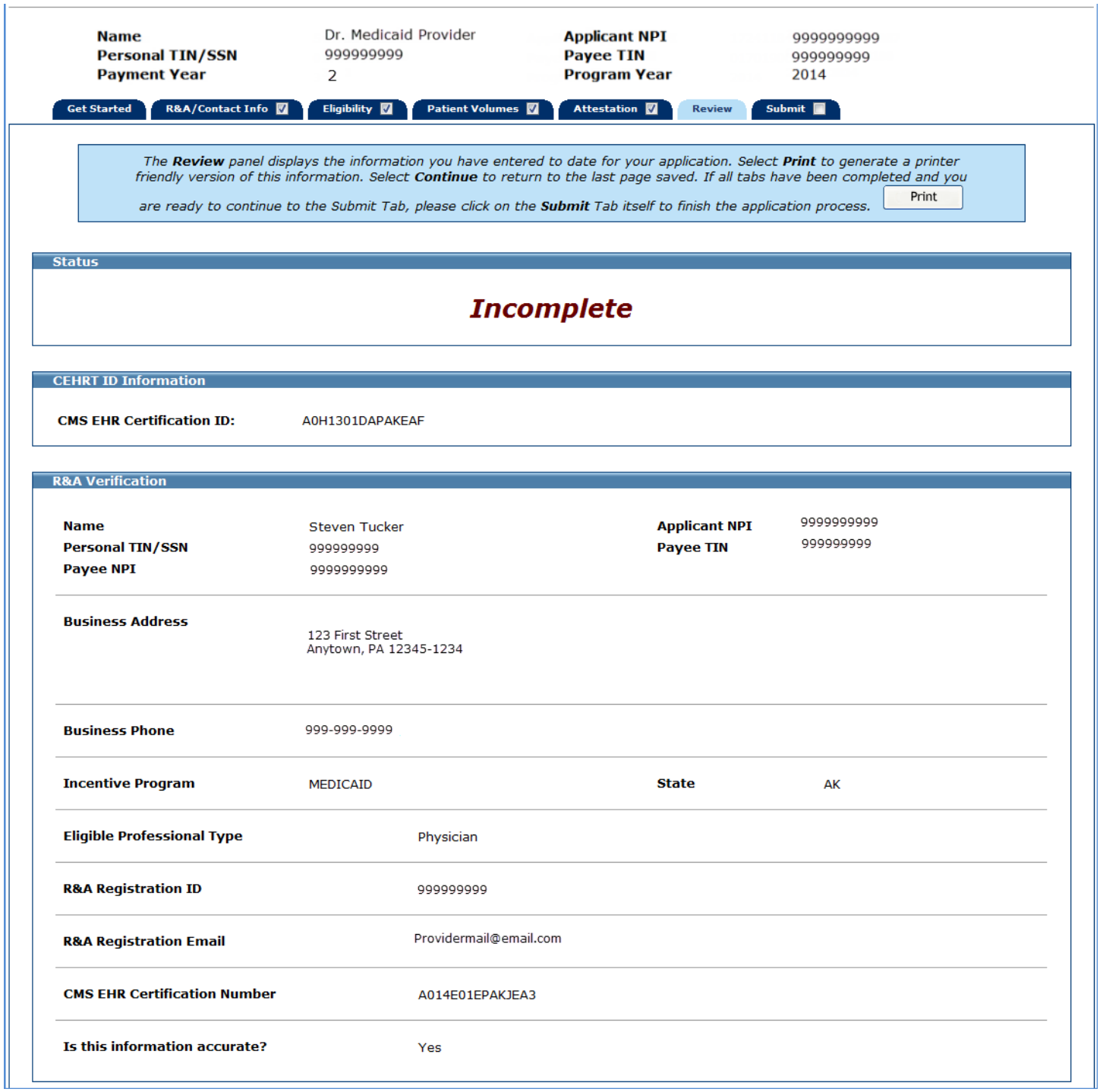
Please review all information carefully before proceeding to the Submit section. After you have submitted your application you will not have the opportunity to change it.

Click **Print** to generate a printer-friendly version of this information.

When you have reviewed all the information, click the **Submit** tab to proceed.

This is screen 1 of 3 of the Review tab display.

Note: If you are in Program Year 2014, the CEHRT ID Information section on the following screen will also display the Meaningful Use Reporting Option and Reason for Delay (if applicable).



This is screen 2 of 3 of the Review tab display.

Primary Contact Information

First Name	John
Last Name	Doe
Phone	999-999-9999
Phone Extension	
Email Address	jdoe@email.com
Department	ECS
Address	4905 Waters Edge Dr raleigh, NE 27607

Alternate Contact Information

First Name	
Last Name	
Phone	
Phone Extension	
Email Address	

Eligibility Questions (Part 1 of 2)

Are you a Hospital based eligible professional?	**No**
I confirm that I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and am only accepting Medicaid Electronic Health Record Incentive Payments from Colorado.	**Yes**

Eligibility Questions (Part 2 of 2)

What type of provider are you?	**Pediatrician**
Do you have any current sanctions or pending sanctions with Medicare or Medicaid in any state?	**No**
Are you currently in compliance with all parts of the HIPAA regulations?	**Yes**
Are you licensed in all states in which you practice?	**No**

Patient Volume Practice Type (Part 1 of 3)

Do you practice predominantly at an FQHC/RHC (over 50% of your total patient encounters occur over a 6 month period in an FQHC/RHC)?	**No**
Please indicate if you are submitting volumes for:	**Individual Practitioner**

Patient Volume 90 Day Period (Part 2 of 3)

Start Date: Oct 01, 2013
End Date: Dec 29, 2013

This is screen 3 of 3 of the Review tab display.

Patient Volume Individual (Part 3 of 3)

Utilizing Certified EHR Technology?	Provider ID	Location Name	Address	Encounter Volumes		%
Yes	9999999999999	Doctor Office	123 First Street Anytown, PA 12345-1234	***Medicaid Only In State:*** ***Total Medicaid:*** ***Denominator:***	100 200 300	67%

Sum Medicaid Only In State Encounter Volume *(Numerator)*	Sum Medicaid Encounter Volume *(Numerator)*	Total Encounter *(Denominator)*	Total %
100	200	300	67%

Attestation Phase (Part 1 of 3)

EHR System Adoption Phase: Meaningful Use - 90 Days

Attestation EHR Reporting Period (Part 1 of 3)

Start Date: Jan 01, 2014
End Date: Mar 31, 2014

Attestation Meaningful Use Measures

Attestation Meaningful Use Measures may be accessed by selecting the link below:
Meaningful Use Measures

Attestation Phase (Part 3 of 3)

Based on the information received from the R&A, you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are receiving that payment as the payee indicated above or you are assigning this payment voluntarily to the payee above and that you have a contractual relationship that allows the assigned employer or entity to bill for your services. **Yes**

You have selected the mailing address below to be used for your Incentive Payment, if you are approved for payment.

Provider ID	Location Name	Address	Additional Information
9999999999, 9999999999	Doctor Office	123 First Street Anytown, PA 12345-1234	

Top

Continue

Step 7 – Submit Your Application

The final submission of your application involves the following steps:

Review and Check Errors - The system will check your application for errors. If errors are present you will have the opportunity to go back to the tab where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, the errors may affect your eligibility and payment amount.

File Upload – File Upload – You will be required to upload documentation supporting your attestation. Files must be in .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 5 MB. The following is a list of documentation requirements:

Documentation required for A/I/U of Certified EHR Technology:

- CMS Certification EHR ID Cart page (2014 edition) showing certification ID and certified EHR product(s) used (this must come from the Certified Health IT Product List (CHPL) website)
- Invoices/Purchase Orders for Certified Electronic Health Record Technology (CEHRT)
- License/Agreement with two signatures
- Documentation supporting patient volume calculations (e.g. Practice Management System reports): **Excel Format preferred**
    - **All Payers List: (clearly showing Medicaid and non-Medicaid patients) containing:**
        - Patients Name
        - Date of Service
        - Date of Birth
        - Medicaid ID where applicable

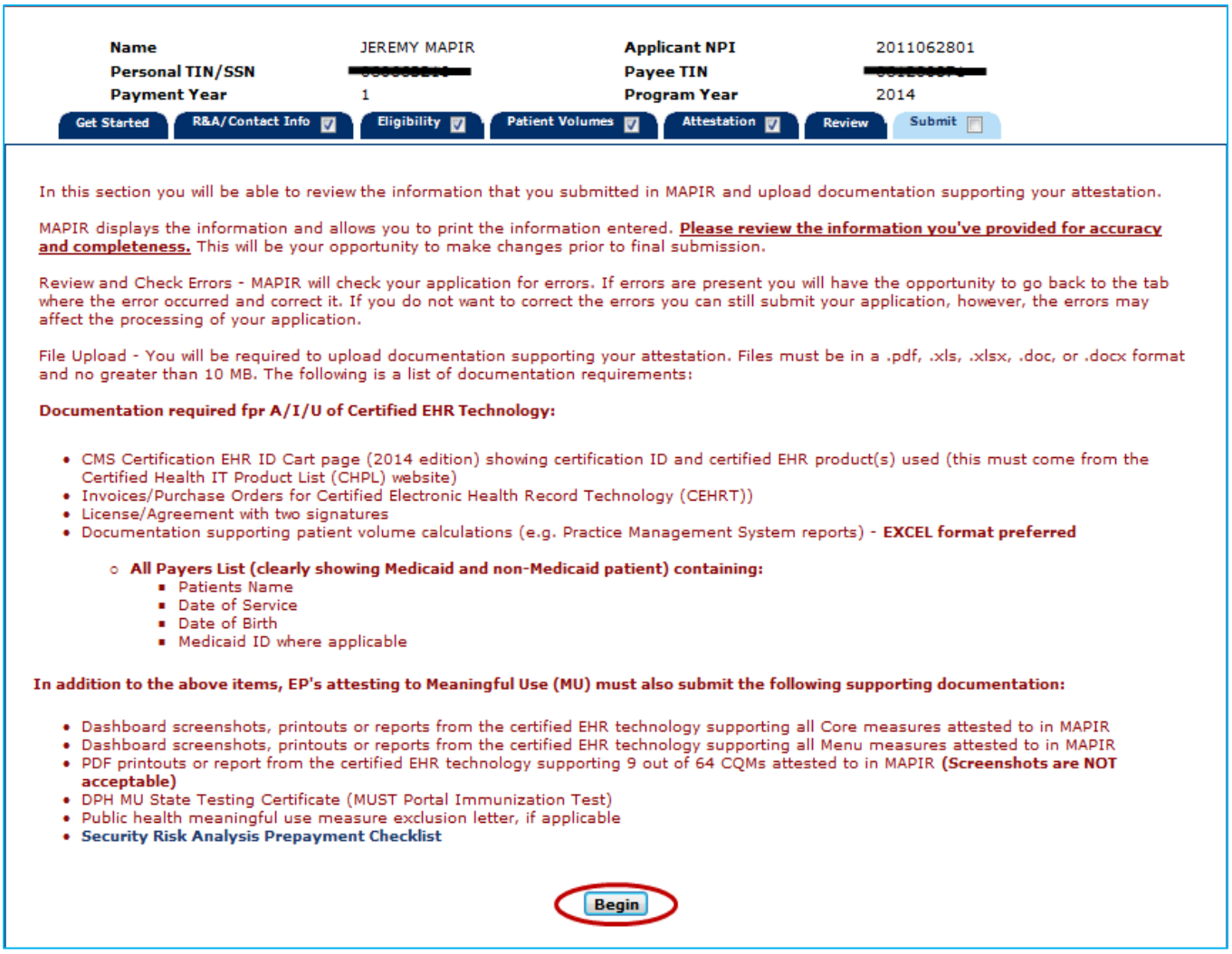
In addition to the above items, EP's attesting to Meaningful Use (MU) must also submit the following supporting documentation:

- Dashboard screenshots, printouts or reports from the certified EHR technology supporting all Core measures attested to in MAPIR
- Dashboard screenshots, printouts or reports from the certified EHR technology supporting all Menu measures attested to in MAPIR
- PDF printouts or report from the certified EHR technology supporting 9 out of 64 CQMs attested to in MAPIR. **(Screenshots are not acceptable)**
- DPH MU State Testing Certificate (MUST Portal Immunization Test)
- Public health meaningful use measure exclusion letter, if applicable
- Security Risk Analysis Prepayment Checklist

Preparer Information - Providers attesting to the EHR Incentive program have two options for completing the electronic signature portion of the application. The provider can perform the submission process, or the provider can designate a preparer to complete the application. If a preparer is completing the application they will navigate through screens to collect the additional required information from the preparer. The provider associated with this application is still responsible for the accuracy of the information provided and attested to.

The initial **Submit** screen contains information about this section.

Click **Begin** to continue to the submission process.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
In this section you will be able to review the information that you submitted in MAPIR and upload documentation supporting your attestation.
MAPIR displays the information and allows you to print the information entered. Please review the information you've provided for accuracy and completeness. This will be your opportunity to make changes prior to final submission.
Review and Check Errors - MAPIR will check your application for errors. If errors are present you will have the opportunity to go back to the tab where the error occurred and correct it. If you do not want to correct the errors you can still submit your application, however, the errors may affect the processing of your application.
File Upload - You will be required to upload documentation supporting your attestation. Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB. The following is a list of documentation requirements:
Documentation required fpr A/I/U of Certified EHR Technology:
CMS Certification EHR ID Cart page (2014 edition) showing certification ID and certified EHR product(s) used (this must come from the Certified Health IT Product List (CHPL) website)
Invoices/Purchase Orders for Certified Electronic Health Record Technology (CEHRT))
License/Agreement with two signatures
Documentation supporting patient volume calculations (e.g. Practice Management System reports) - EXCEL format preferred
All Payers List (clearly showing Medicaid and non-Medicaid patient) containing:
Patients Name
Date of Service
Date of Birth
Medicaid ID where applicable
In addition to the above items, EP's attesting to Meaningful Use (MU) must also submit the following supporting documentation:
Dashboard screenshots, printouts or reports from the certified EHR technology supporting all Core measures attested to in MAPIR
Dashboard screenshots, printouts or reports from the certified EHR technology supporting all Menu measures attested to in MAPIR
PDF printouts or report from the certified EHR technology supporting 9 out of 64 CQMs attested to in MAPIR (Screenshots are NOT acceptable)
DPH MU State Testing Certificate (MUST Portal Immunization Test)
Public health meaningful use measure exclusion letter, if applicable
Security Risk Analysis Prepayment Checklist
Begin

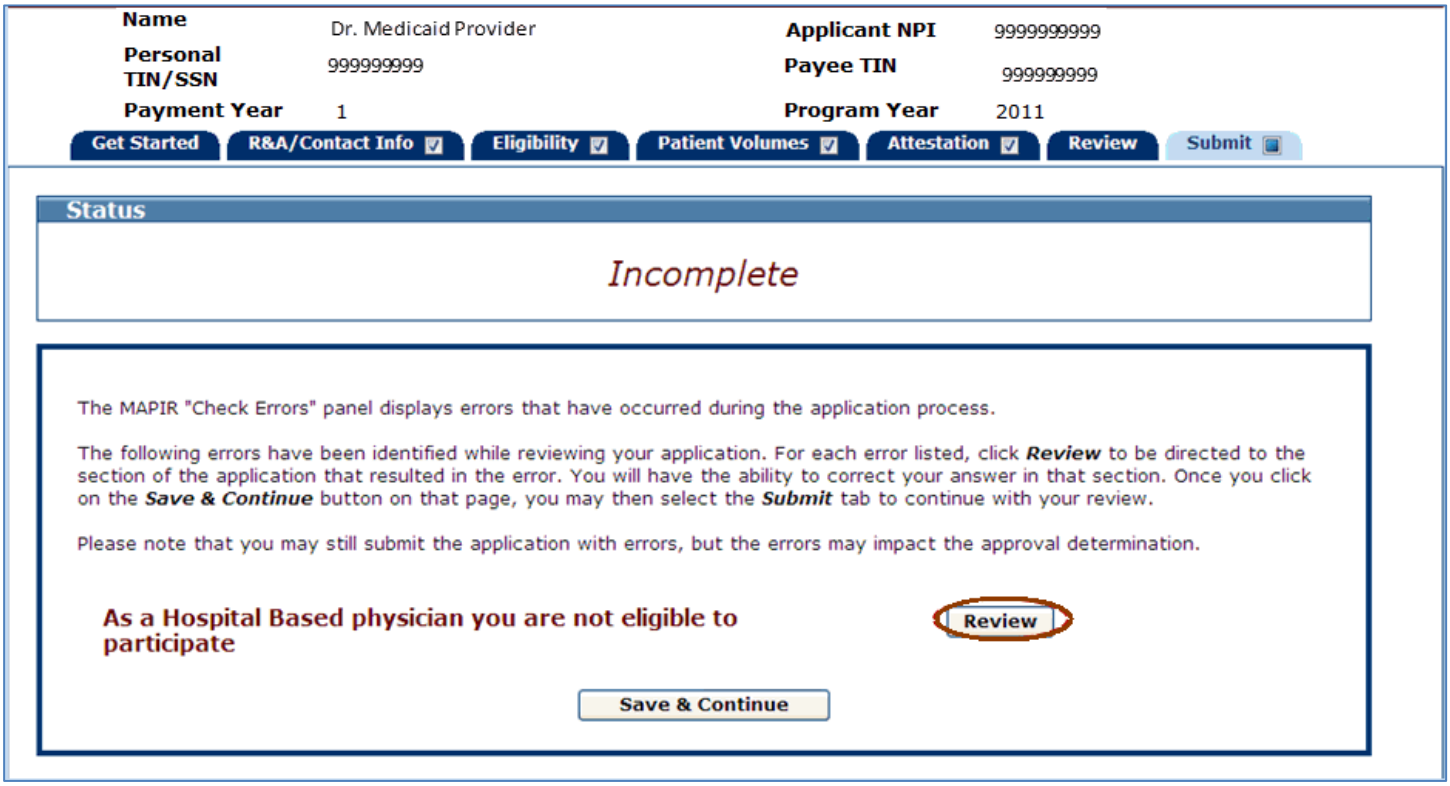
This screen lists the current status of your application and any error messages identified by the system.

You can correct these errors or leave them as is. You can submit this application with errors; however, errors may impact your eligibility and incentive payment amount.

To correct errors:

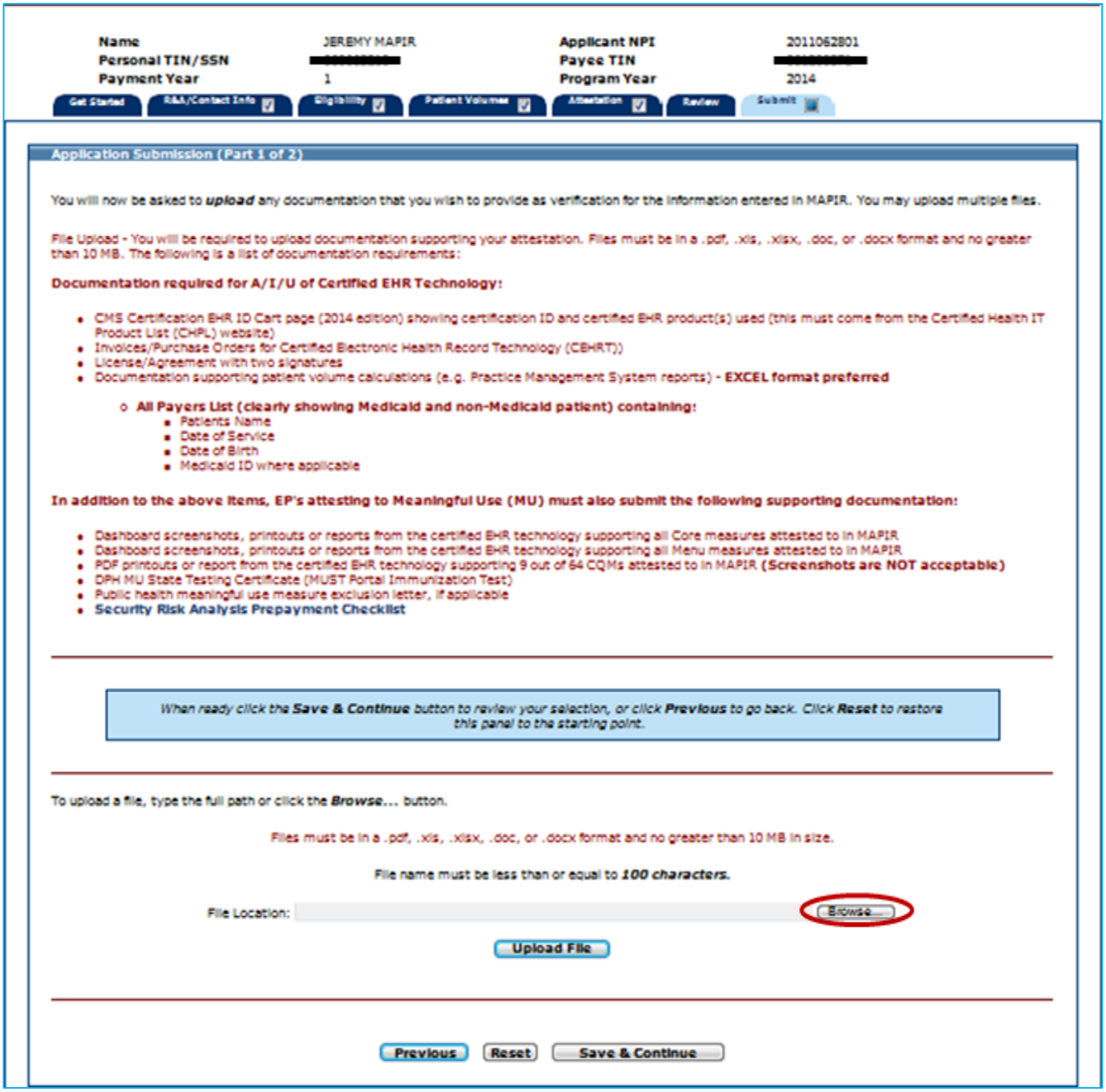
Click **Review** to be taken to the section in error and correct the information. To return to this section at any time click the **Submit** tab.

Click **Save & Continue** to continue with the application submission.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Status
Incomplete
The MAPIR "Check Errors" panel displays errors that have occurred during the application process.
The following errors have been identified while reviewing your application. For each error listed, click Review to be directed to the section of the application that resulted in the error. You will have the ability to correct your answer in that section. Once you click on the Save & Continue button on that page, you may then select the Submit tab to continue with your review.
Please note that you may still submit the application with errors, but the errors may impact the approval determination.
As a Hospital Based physician you are not eligible to participate
Review
Save & Continue

To upload files click **Browse** to navigate to the file you wish to upload.

Note: Excel, Word and Portable Data Format (PDF) files up to 10 megabytes (MB) in size are acceptable documentation to upload.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
You will now be asked to upload any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.
File Upload - You will be required to upload documentation supporting your attestation. Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB. The following is a list of documentation requirements:
Documentation required for A/I/U of Certified EHR Technology:
CMS Certification EHR ID Cert page (2014 edition) showing certification ID and certified EHR product(s) used (this must come from the Certified Health IT Product List (CHPL) website)
Invoices/Purchase Orders for Certified Electronic Health Record Technology (CEHRT))
License/Agreement with two signatures
Documentation supporting patient volume calculations (e.g. Practice Management System reports) - EXCEL format preferred
All Payers List (clearly showing Medicaid and non-Medicaid patient) containing:
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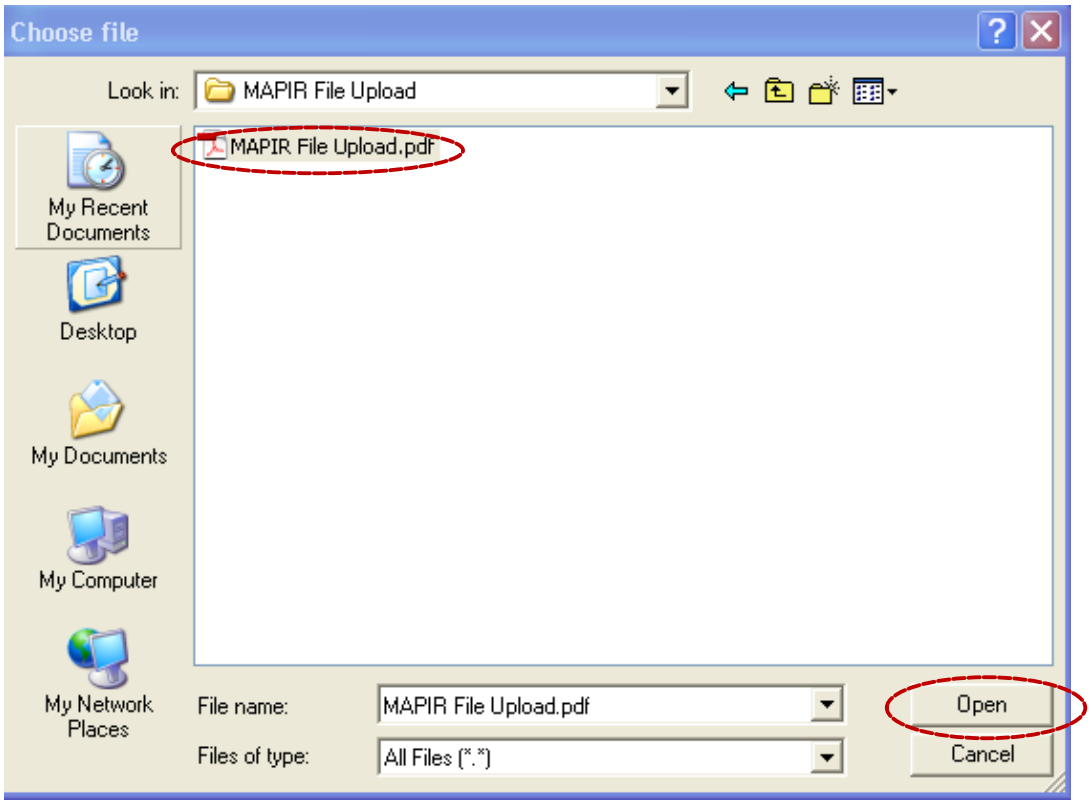
DPH MU State Testing Certificate (MUST Portal Immunization Test)
Public health meaningful use measure exclusion letter, if applicable
Security Risk Analysis Prepayment Checklist
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
To upload a file, type the full path or click the Browse... button.
Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB in size.
File name must be less than or equal to 100 characters.
File Location:
Browse...
Upload File
Previous
Reset
Save & Continue

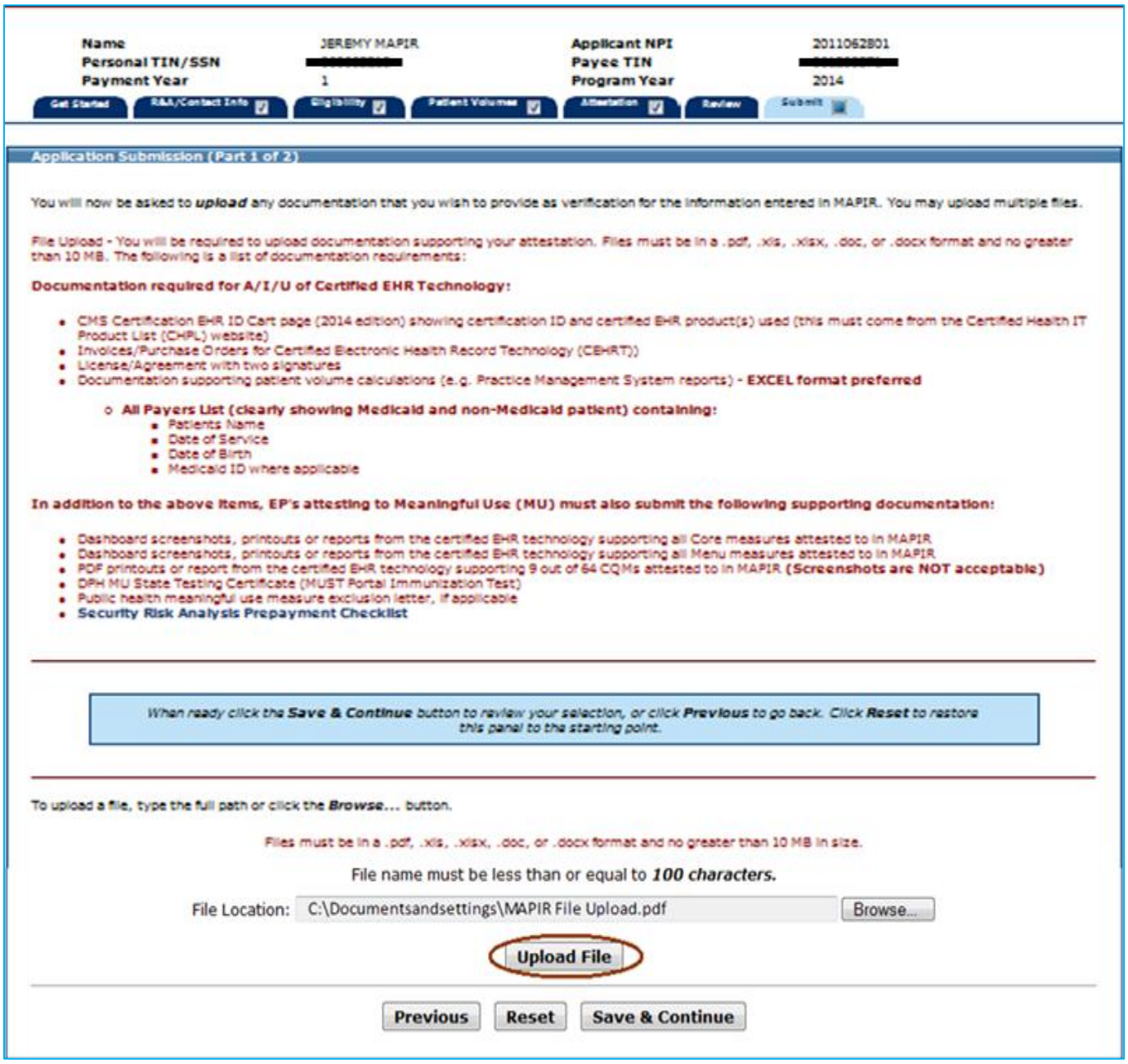
The **Choose file** dialog box will display.

Navigate to the file you want to upload and select **Open**.



Check the file name in the file name box.

Click **Upload File** to begin the file upload process.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
You will now be asked to upload any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.
File Upload - You will be required to upload documentation supporting your attestation. Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB. The following is a list of documentation requirements:
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License/Agreement with two signatures
Documentation supporting patient volume calculations (e.g. Practice Management System reports) - EXCEL format preferred
All Payers List (clearly showing Medicaid and non-Medicaid patient) containing:
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Medicaid ID where applicable
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DPH MU State Testing Certificate (MUST Portal Immunization Test)
Public health meaningful use measure exclusion letter, if applicable
Security Risk Analysis Prepayment Checklist
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
To upload a file, type the full path or click the Browse... button.
Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB in size.
File name must be less than or equal to 100 characters.
File Location:
C:\Documentsandsettings\MAPIR File Upload.pdf
Browse...
Upload File
Previous
Reset
Save & Continue

Note the "File has been successfully uploaded." message. Review the uploaded file list in the Uploaded Files box.

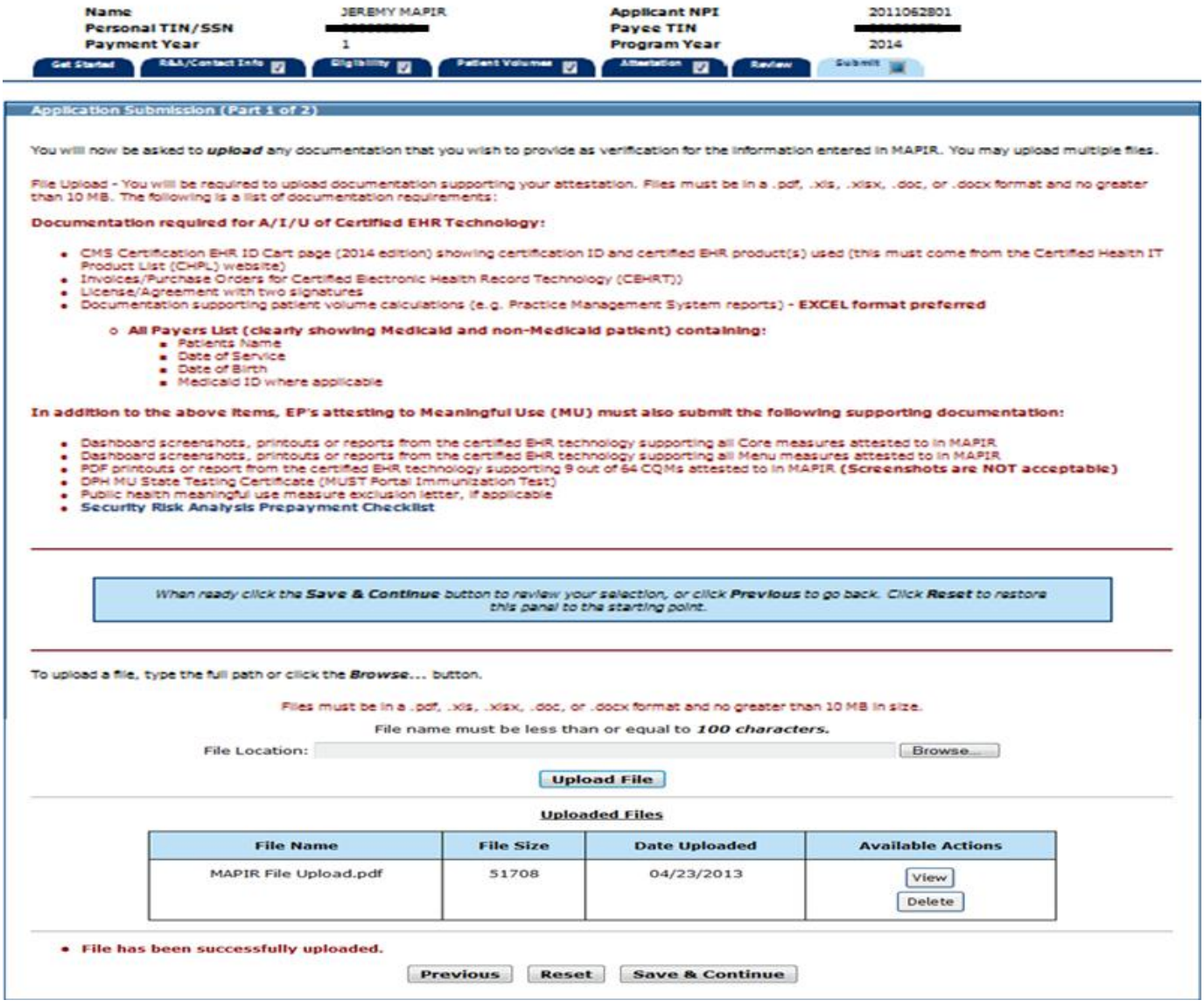
If you have more than one file to upload, repeat the steps to select and upload a file as many times a necessary.

All of the files you uploaded will be listed in the **Uploaded Files** section of the screen. The Upload Files screen may also display files that were uploaded by an Administrative User and made available for you to view.

To view the uploaded file click **View** in the Available Actions column.

To delete an uploaded file click **Delete** in the Available Actions column. If a file is uploaded by an Administrative User, you will not have the option to delete the file.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
You will now be asked to upload any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.
File Upload - You will be required to upload documentation supporting your attestation. Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB. The following is a list of documentation requirements:
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Invoices/Purchase Orders for Certified Electronic Health Record Technology (CEHRT))
License/Agreement with two signatures
Documentation supporting patient volume calculations (e.g. Practice Management System reports) - EXCEL format preferred
All Payers List (clearly showing Medicaid and non-Medicaid patient) containing:
Patients Name
Date of Service
Date of Birth
Medicaid ID where applicable
In addition to the above items, EP's attesting to Meaningful Use (MU) must also submit the following supporting documentation:
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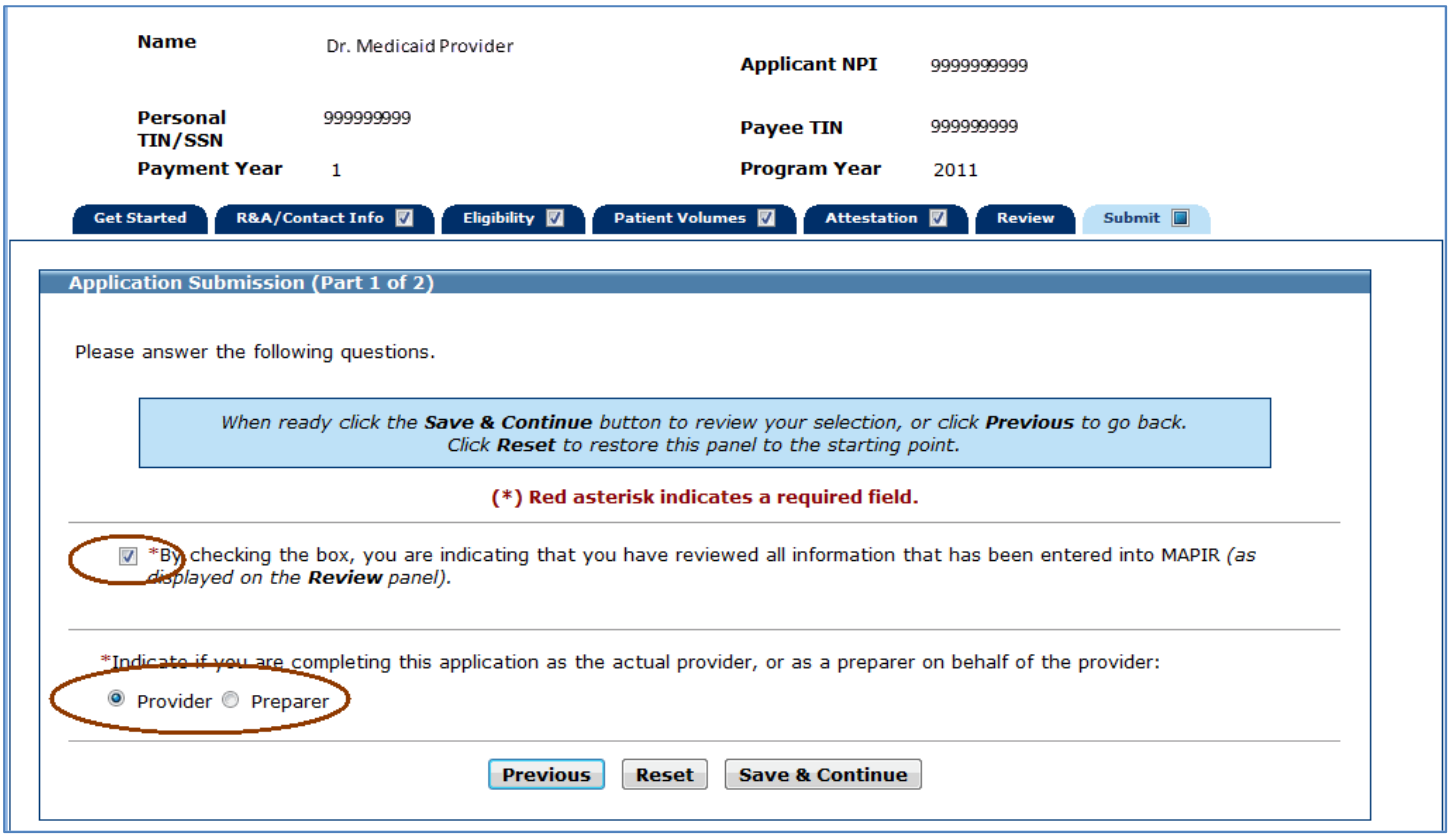
Public health meaningful use measure exclusion letter, if applicable
Security Risk Analysis Prepayment Checklist
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
To upload a file, type the full path or click the Browse... button.
Files must be in a .pdf, .xls, .xlsx, .doc, or .docx format and no greater than 10 MB in size.
File name must be less than or equal to 100 characters.
File Location:
Browse...
Upload File
Uploaded Files
File Name
File Size
Date Uploaded
Available Actions
MAPIR File Upload.pdf
51708
04/23/2013
View
Delete
File has been successfully uploaded.
Previous
Reset
Save & Continue

Select the check box to acknowledge that you have reviewed all of your information.

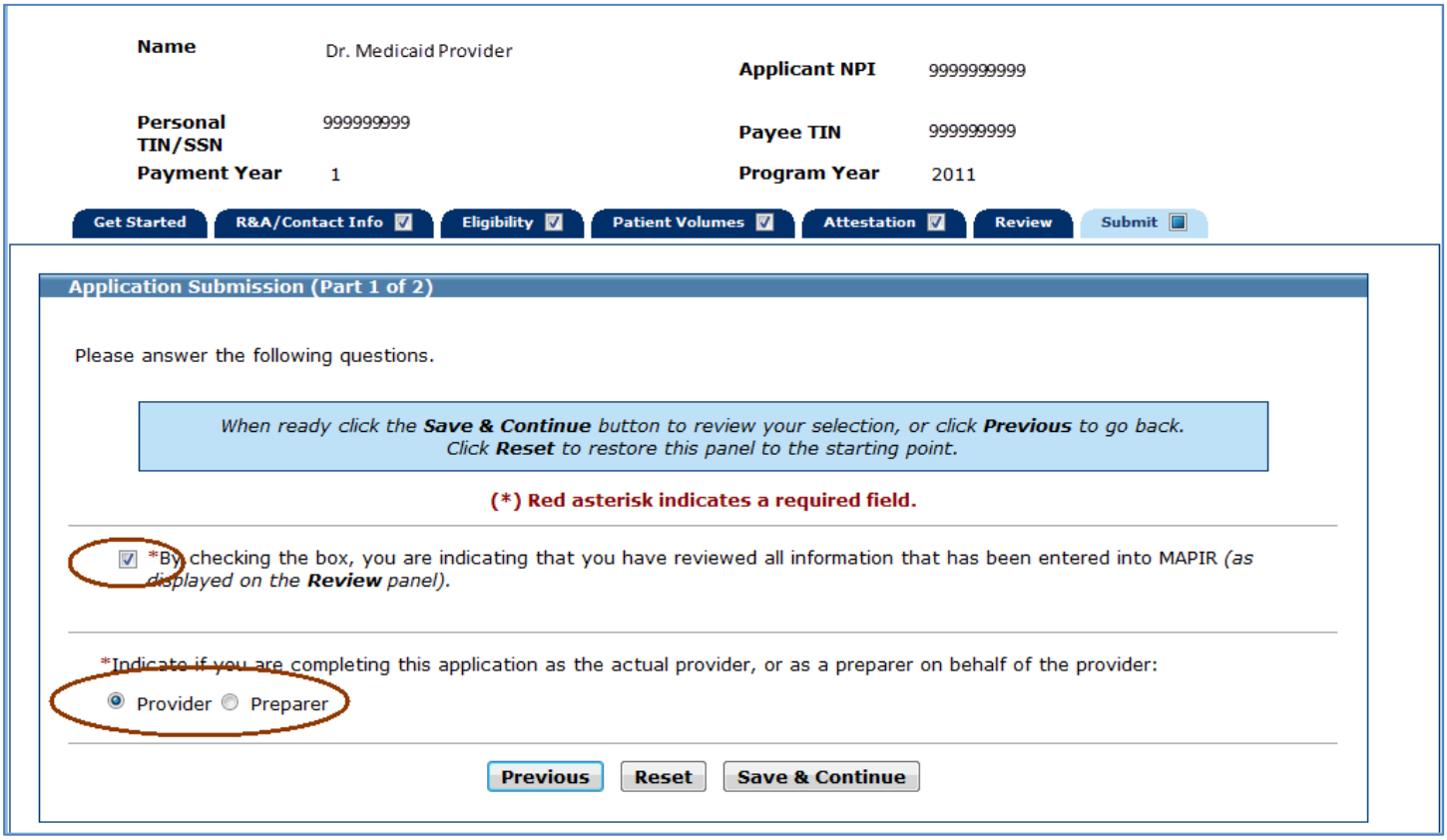
Select the **Provider** or **Preparer** button, as appropriate.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
Please answer the following questions.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*By checking the box, you are indicating that you have reviewed all information that has been entered into MAPIR (as displayed on the Review panel).
*Indicate if you are completing this application as the actual provider, or as a preparer on behalf of the provider:
Provider
Preparer
Previous
Reset
Save & Continue

This screen depicts **Provider** selection.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.

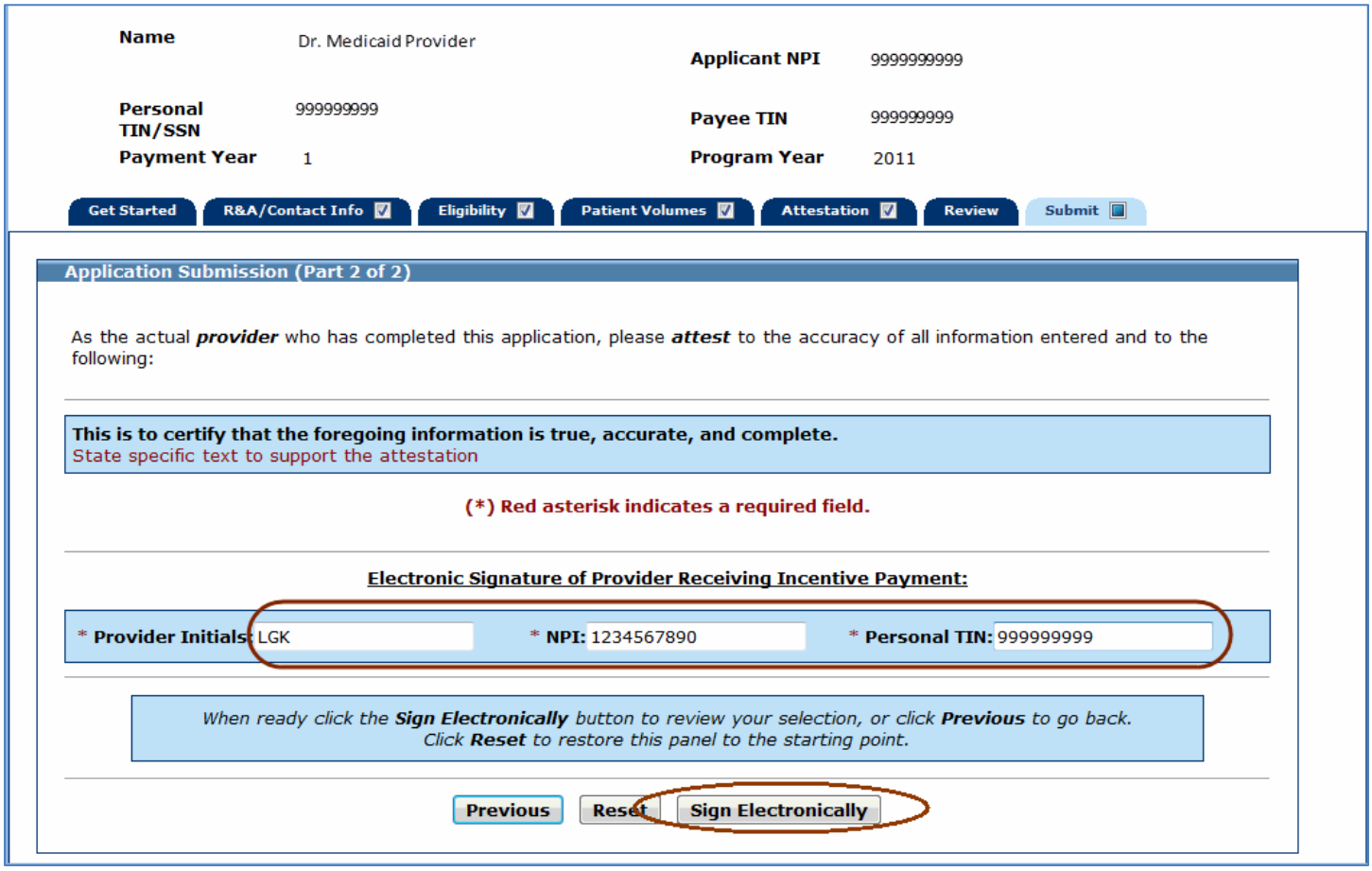

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
Please answer the following questions.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*By checking the box, you are indicating that you have reviewed all information that has been entered into MAPIR (as displayed on the Review panel).
*Indicate if you are completing this application as the actual provider, or as a preparer on behalf of the provider:
Provider
Preparer
Previous
Reset
Save & Continue

This screen depicts the Provider signature screen.

Enter your **Provider Initials, NPI,** and **Personal TIN**.

Click **Sign Electronically** to proceed.

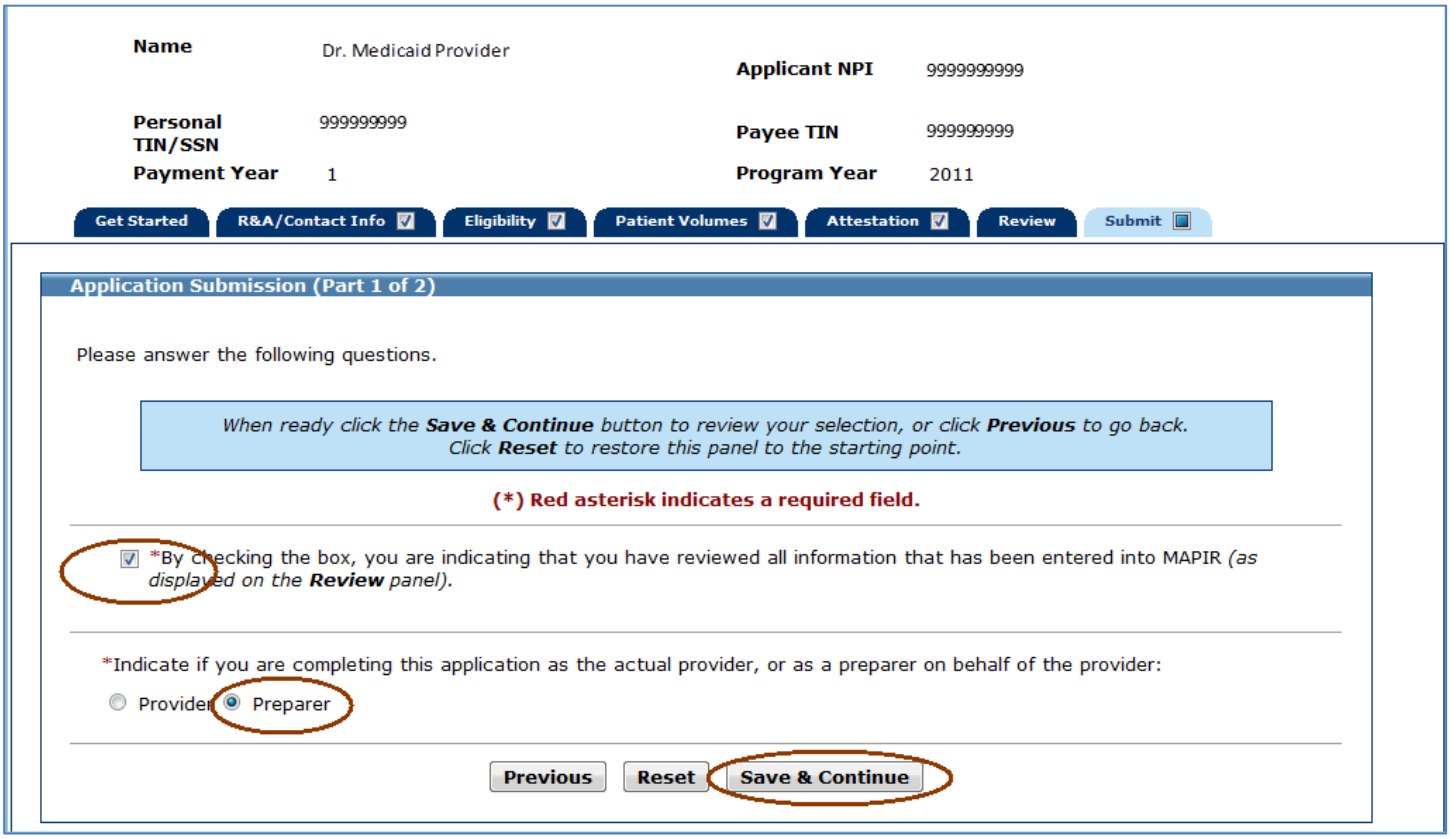
Click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 2 of 2)
As the actual provider who has completed this application, please attest to the accuracy of all information entered and to the following:
This is to certify that the foregoing information is true, accurate, and complete.
State specific text to support the attestation
(*) Red asterisk indicates a required field.
Electronic Signature of Provider Receiving Incentive Payment:
* Provider Initials: LGK
* NPI: 1234567890
* Personal TIN: 999999999
When ready click the Sign Electronically button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
Previous
Reset
Sign Electronically

This screen depicts the signature screen for a Preparer on behalf of the provider.

As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

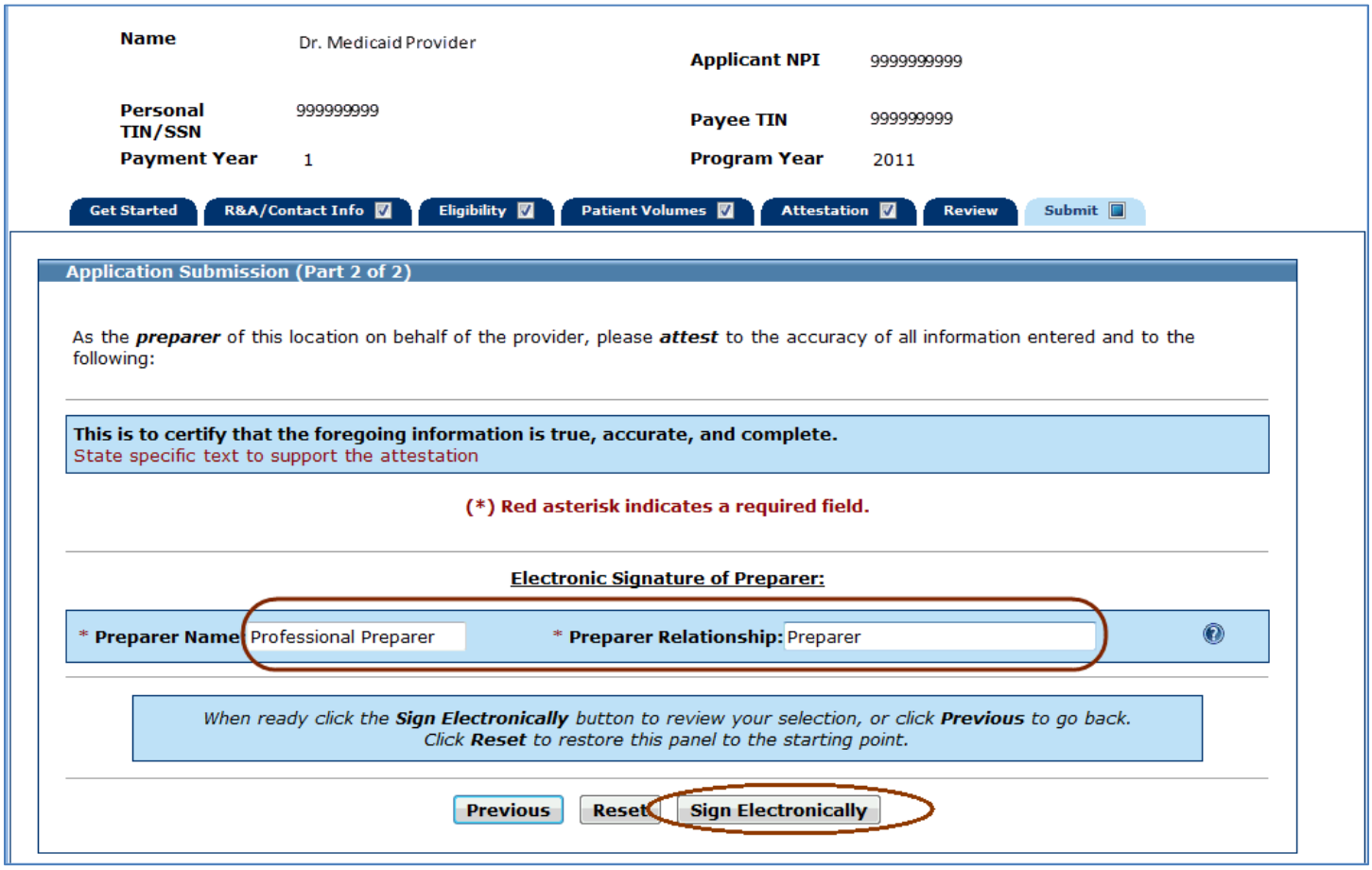
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 1 of 2)
Please answer the following questions.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
*By checking the box, you are indicating that you have reviewed all information that has been entered into MAPIR (as displayed on the Review panel).
*Indicate if you are completing this application as the actual provider, or as a preparer on behalf of the provider:
Provider
Preparer
Previous
Reset
Save & Continue

As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

Enter your **Preparer Name** and **Preparer Relationship** to the provider.

Click **Sign Electronically** to review your selection, or click **Previous** to return. Click **Reset** to restore this panel to the starting point or last saved data.



After electronically signing the application, MAPIR determines if the Meaningful Use attestation data you attested to is accepted or rejected. If your Meaningful Use attestation data is rejected, the following screen will display.

If your Meaningful Use attestation data is accepted, this screen will not display. Proceed to the following page.

Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN 060663210
Payee TIN 361924026
Payment Year 1
Program Year 2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 2 of 2)
The Meaningful Use Attestation data that you have attested to has failed to meet mandatory requirements. At this point in time you may opt to submit the application or return to the Attestation Tab to review or revise any data that has been entered.
By signing electronically you have attested to the accuracy of the Meaningful Use data that has been entered. Please be advised that multiple attempts to complete the Meaningful Use data, may result in an audit of the data.
Note: Mandatory requirements must be met to qualify for an incentive payment.
Click the Attestation tab to return to Meaningful Use Attestation, or the Save & Continue button to review your selection, or click Previous to go back.
Attestation Meaningful Use Measures
Click the link below to review the Attestation Meaningful Use Measure data that has been entered, as well as the acceptance or rejection outcome for each measure.
If you wish you retain this information for the future reference, please print the information after selecting the link. It will be necessary to Sign Electronically to view the acceptance and rejection outcome of measures after leaving this page.
Meaningful Use Measures
STOP
Please note you have not met the minimum meaningful use requirements.
You are advised to review the details above before proceeding.
Previous
Save & Continue

Click on the **Meaningful Use Measures** link to review the Meaningful Use attestation data that you entered as well as the acceptance or rejection outcome for each measure. Click on the **Attestation** tab to return to the Meaningful Use Attestation where you can revise the Meaningful Use attestation data.

Please note that you may be subject to an audit after frequent attempts at correcting failed measures.

Also note that while you have the option to continue with your submission by clicking **Save & Continue**, if you do not meet the mandatory requirements, you will not receive an incentive payment.

Click **Previous** to go back or click the **Save & Continue** to proceed with the submission of your application.

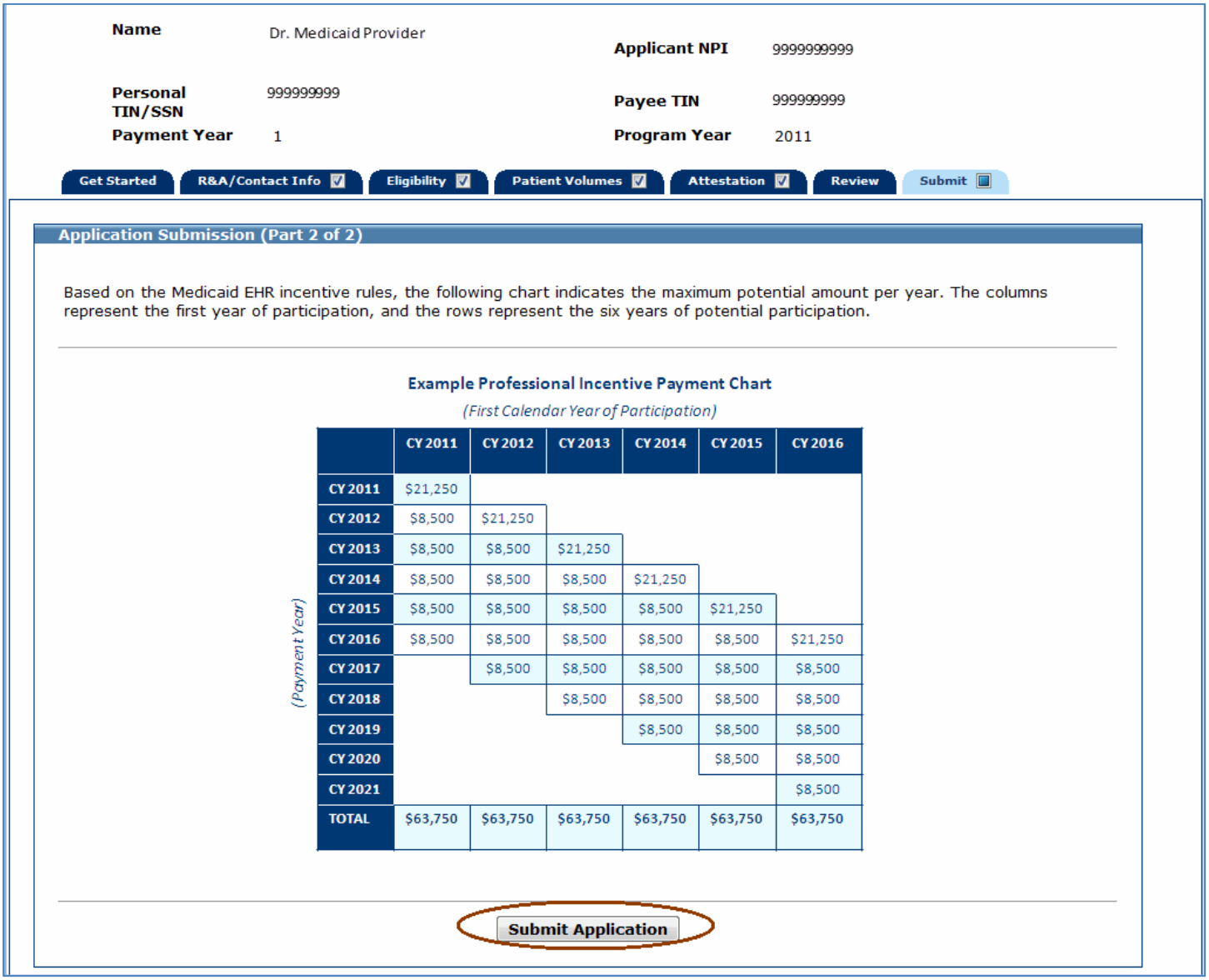
This is an example of an incentive payment chart for a **Non Pediatric Professional** whose patient volume meets 30% eligibility requirement.

No information is required on this screen.

The incentive payment chart example for Pediatricians is shown on the next page.

Note: This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.

Click **Submit Application** to continue.

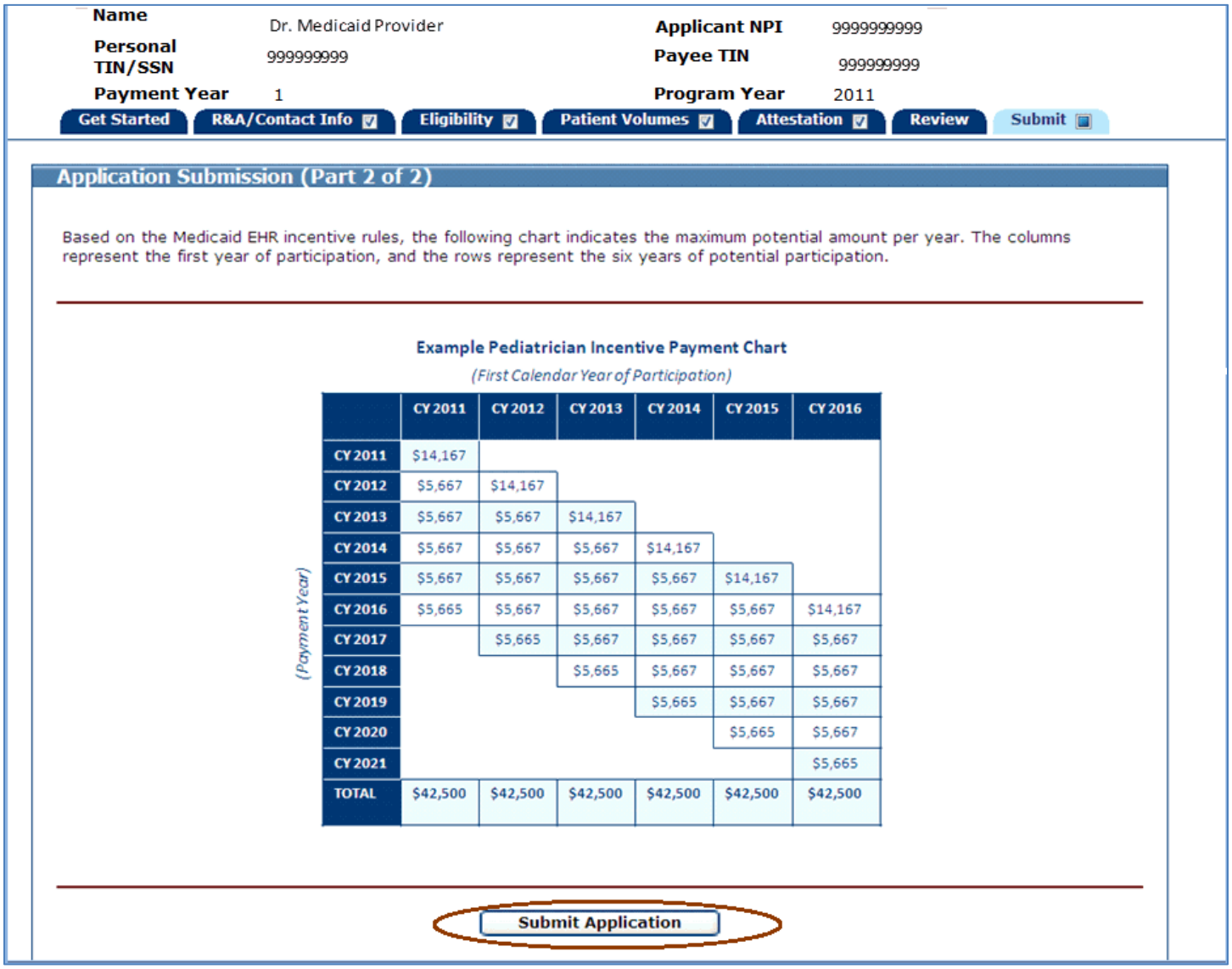

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 2 of 2)
Based on the Medicaid EHR incentive rules, the following chart indicates the maximum potential amount per year. The columns represent the first year of participation, and the rows represent the six years of potential participation.
Example Professional Incentive Payment Chart
(First Calendar Year of Participation)
(Payment Year)
CY 2011 CY 2012 CY 2013 CY 2014 CY 2015 CY 2016
CY 2011 $21,250
CY 2012 $8,500 $21,250
CY 2013 $8,500 $8,500 $21,250
CY 2014 $8,500 $8,500 $8,500 $21,250
CY 2015 $8,500 $8,500 $8,500 $8,500 $21,250
CY 2016 $8,500 $8,500 $8,500 $8,500 $8,500 $21,250
CY 2017 $8,500 $8,500 $8,500 $8,500 $8,500
CY 2018 $8,500 $8,500 $8,500 $8,500
CY 2019 $8,500 $8,500 $8,500
CY 2020 $8,500 $8,500
CY 2021 $8,500
TOTAL $63,750 $63,750 $63,750 $63,750 $63,750 $63,750
Submit Application

This is an example of an incentive payment chart for a **Pediatric Professional** whose patient volume meets the 20% requirement but is less than 30%**.**

No information is required on this screen.

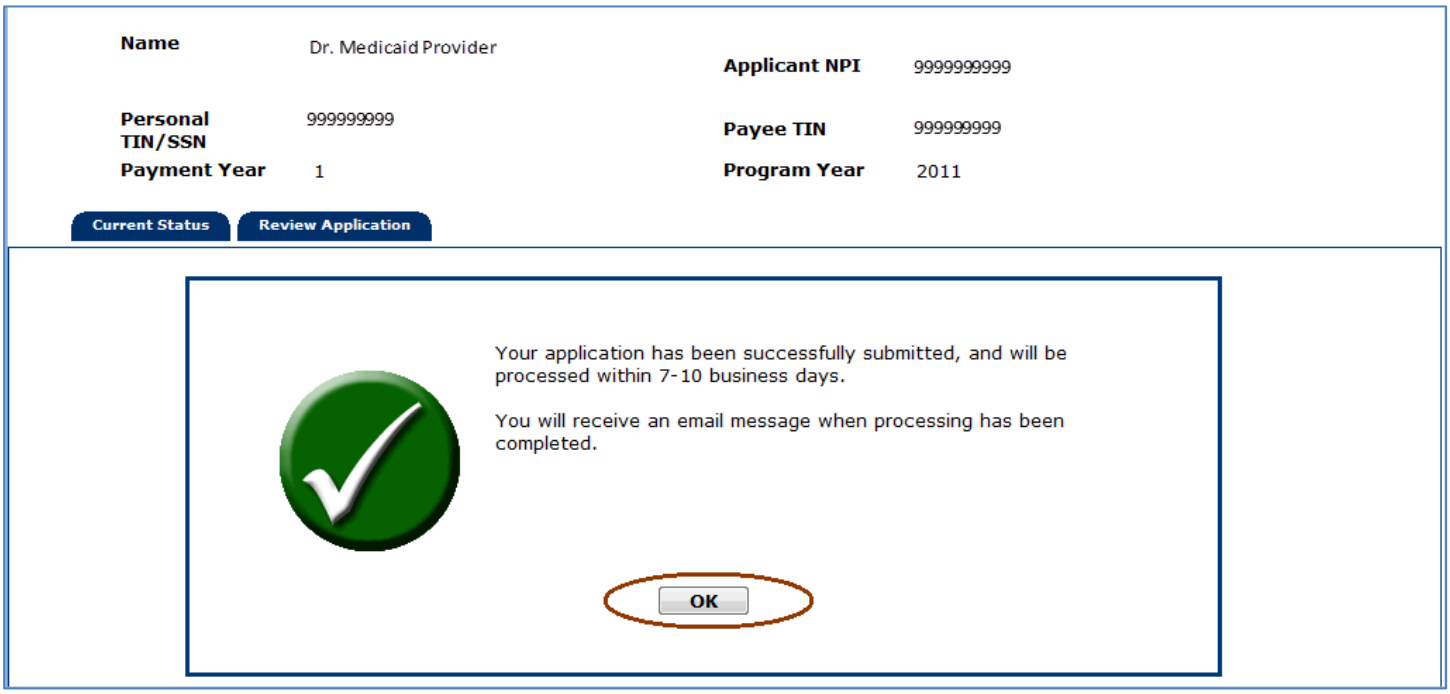
Note: This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.

Click **Submit Application**.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2011
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Application Submission (Part 2 of 2)
Based on the Medicaid EHR incentive rules, the following chart indicates the maximum potential amount per year. The columns represent the first year of participation, and the rows represent the six years of potential participation.
Example Pediatrician Incentive Payment Chart
(First Calendar Year of Participation)
(Payment Year)
CY 2011 CY 2012 CY 2013 CY 2014 CY 2015 CY 2016
CY 2011 $14,167
CY 2012 $5,667 $14,167
CY 2013 $5,667 $5,667 $14,167
CY 2014 $5,667 $5,667 $5,667 $14,167
CY 2015 $5,667 $5,667 $5,667 $5,667 $14,167
CY 2016 $5,665 $5,667 $5,667 $5,667 $5,667 $14,167
CY 2017 $5,665 $5,667 $5,667 $5,667 $5,667
CY 2018 $5,665 $5,667 $5,667 $5,667
CY 2019 $5,665 $5,667 $5,667
CY 2020 $5,665 $5,667
CY 2021 $5,665
TOTAL $42,500 $42,500 $42,500 $42,500 $42,500 $42,500
Submit Application

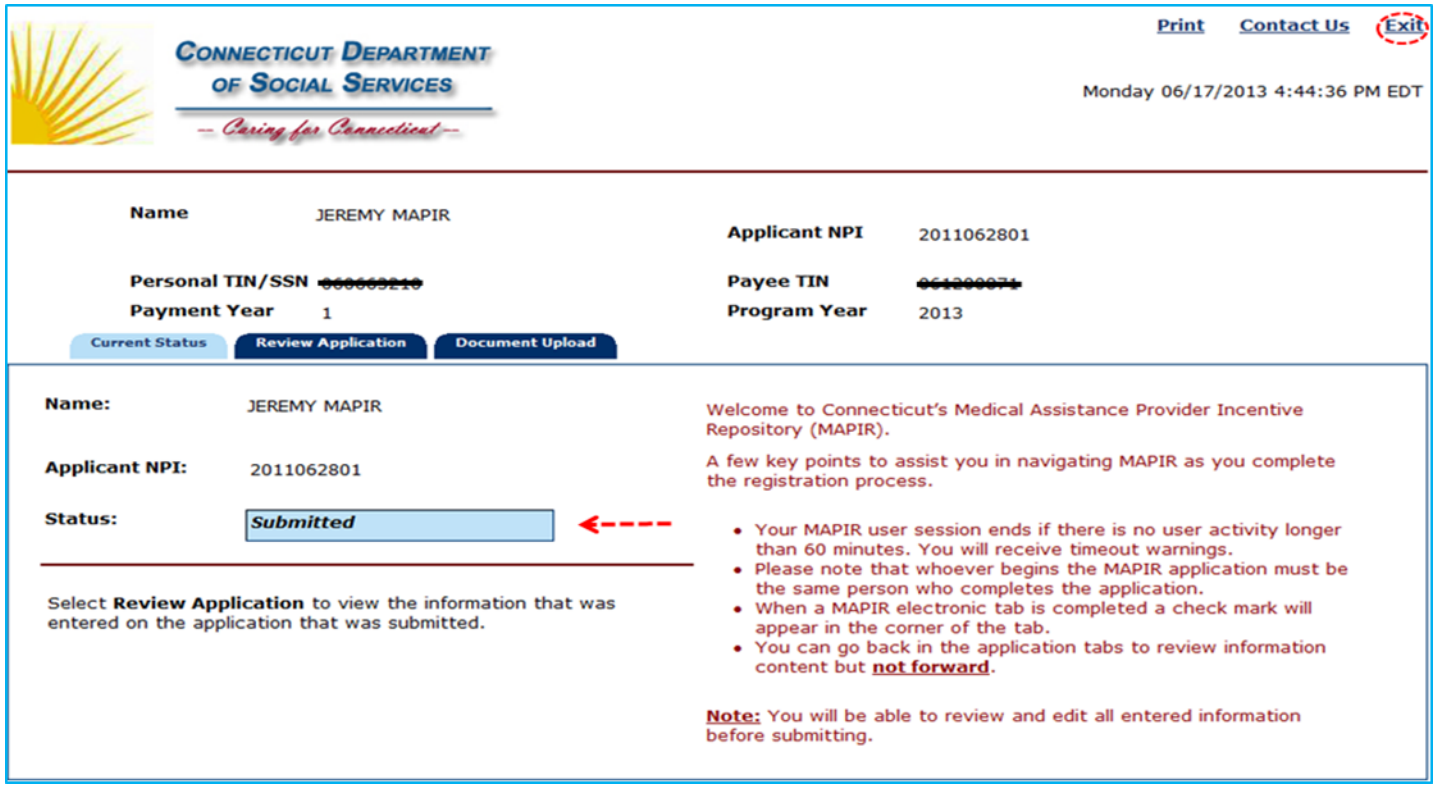
The check indicates your application has been successfully submitted.

Click **OK**.

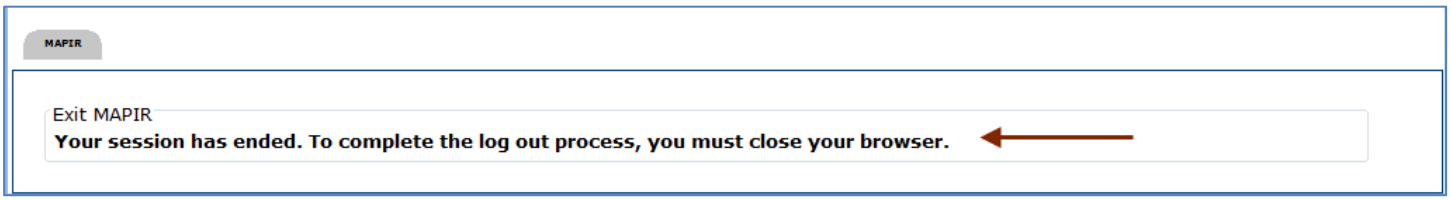


When your application has been successfully submitted, you will see the application status of Submitted. You can click the Review Application tab to review your application; however, you will not be able to make changes

Click **Exit** to exit MAPIR.


Print
Contact Us
Exit
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
Caring for Connecticut
Monday 06/17/2013 4:44:36 PM EDT
Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN
Payee TIN
Payment Year 1
Program Year 2013
Current Status
Review Application
Document Upload
Name: JEREMY MAPIR
Applicant NPI: 2011062801
Status: Submitted
Select Review Application to view the information that was entered on the application that was submitted.
Welcome to Connecticut's Medical Assistance Provider Incentive Repository (MAPIR).
A few key points to assist you in navigating MAPIR as you complete the registration process.
Your MAPIR user session ends if there is no user activity longer than 60 minutes. You will receive timeout warnings.
Please note that whoever begins the MAPIR application must be the same person who completes the application.
When a MAPIR electronic tab is completed a check mark will appear in the corner of the tab.
You can go back in the application tabs to review information content but not forward.
Note: You will be able to review and edit all entered information before submitting.

This screen shows that your MAPIR session has ended. You should now close your browser window.

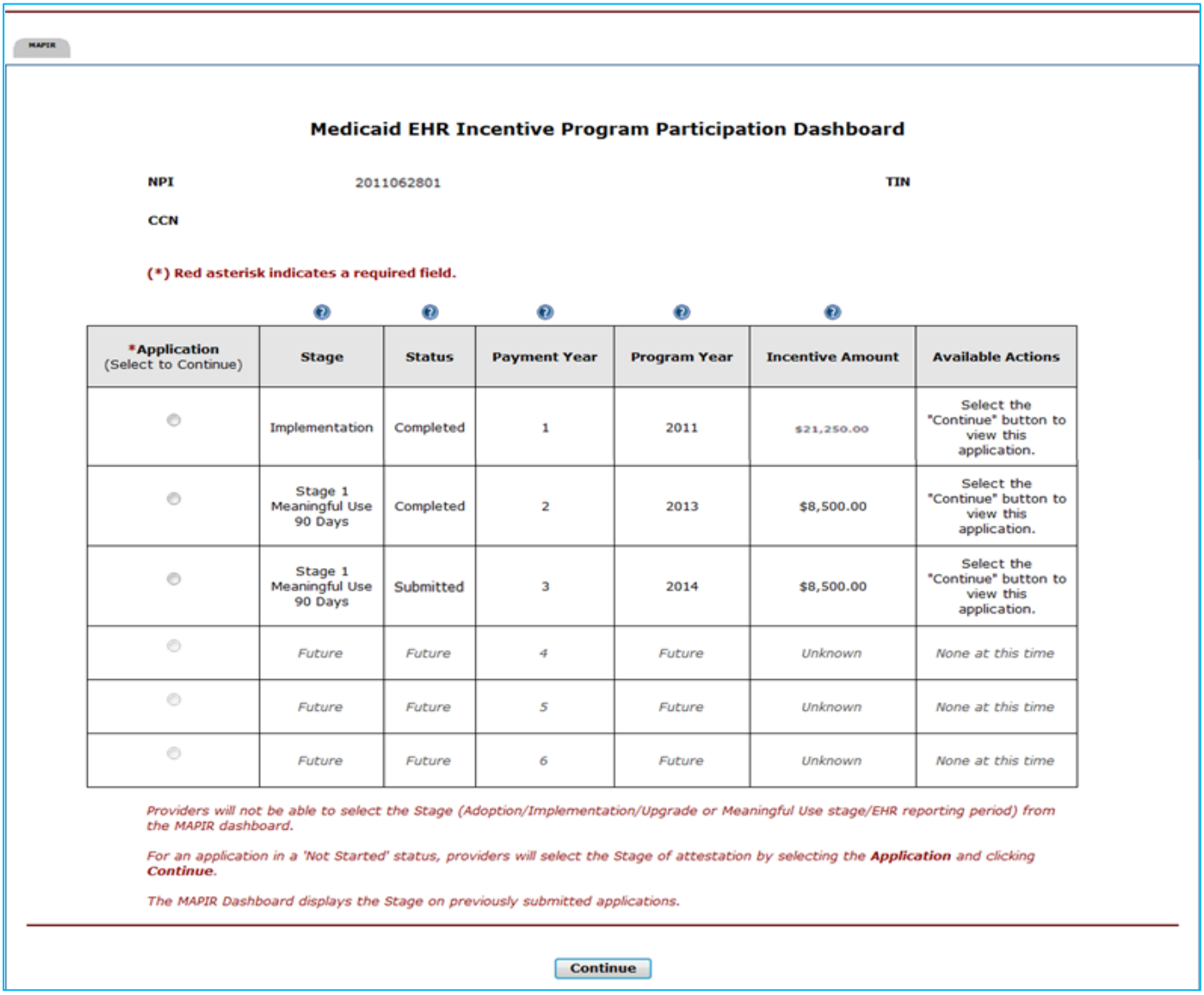


Post Submission Activities

This section contains information about post application submission activities. At any time you can check the status of your application by logging into the Connecticut Medicaid portal. Once you have successfully completed the application submission process you will receive an email confirming your submission has been received. You may also receive email updates as your application is processed.

When you log in to MAPIR after submitting your application you will see the Medicaid EHR Incentive Program Participation Dashboard.

Notice that the Status of your application is Submitted. You can only view an application in a Submitted status. The next payment year application will be enabled when you become eligible to apply. For status information, please see the Status Definition table in the Post Submission Activities section of this manual.



MAPIR

Medicaid EHR Incentive Program Participation Dashboard

NPI 2011062801 **TIN**

CCN

(*) Red asterisk indicates a required field.

*Application (Select to Continue)	Stage	Status	Payment Year	Program Year	Incentive Amount	Available Actions
○	Implementation	Completed	1	2011	$21,250.00	Select the "Continue" button to view this application.
○	Stage 1 Meaningful Use 90 Days	Completed	2	2013	$8,500.00	Select the "Continue" button to view this application.
○	Stage 1 Meaningful Use 90 Days	Submitted	3	2014	$8,500.00	Select the "Continue" button to view this application.
○	*Future*	*Future*	*4*	*Future*	*Unknown*	*None at this time*
○	*Future*	*Future*	*5*	*Future*	*Unknown*	*None at this time*
○	*Future*	*Future*	*6*	*Future*	*Unknown*	*None at this time*

Providers will not be able to select the Stage (Adoption/Implementation/Upgrade or Meaningful Use stage/EHR reporting period) from the MAPIR dashboard.

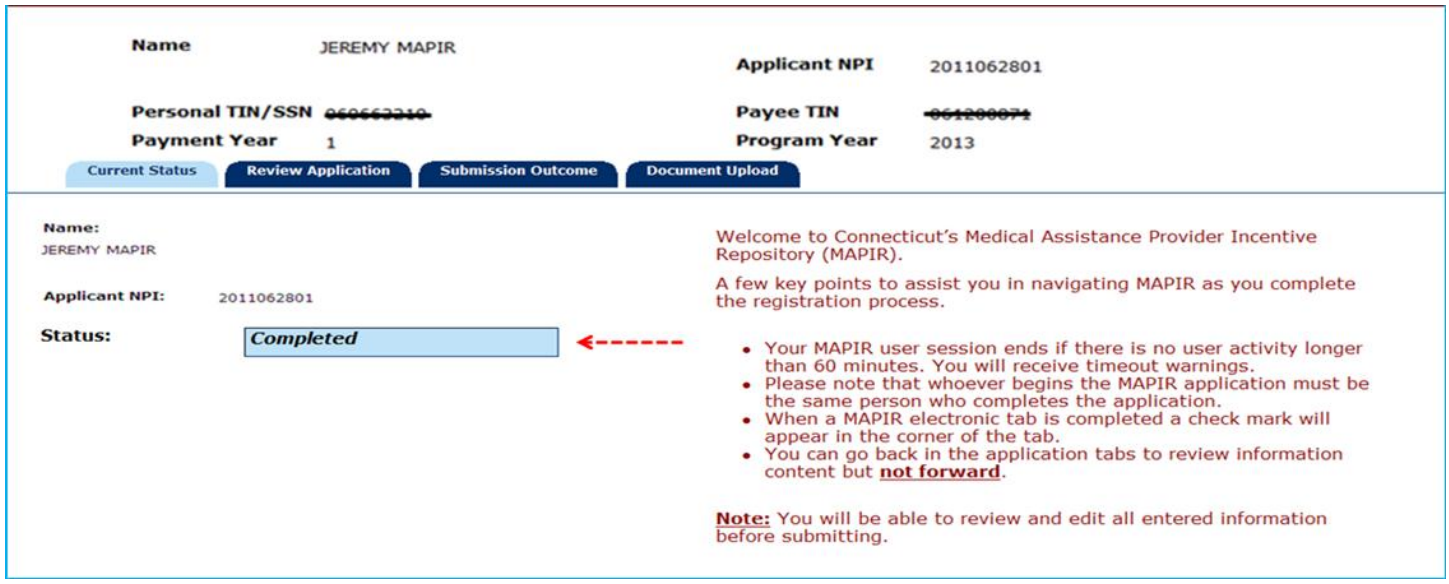
*For an application in a 'Not Started' status, providers will select the Stage of attestation by selecting the **Application** and clicking **Continue**.*

The MAPIR Dashboard displays the Stage on previously submitted applications.

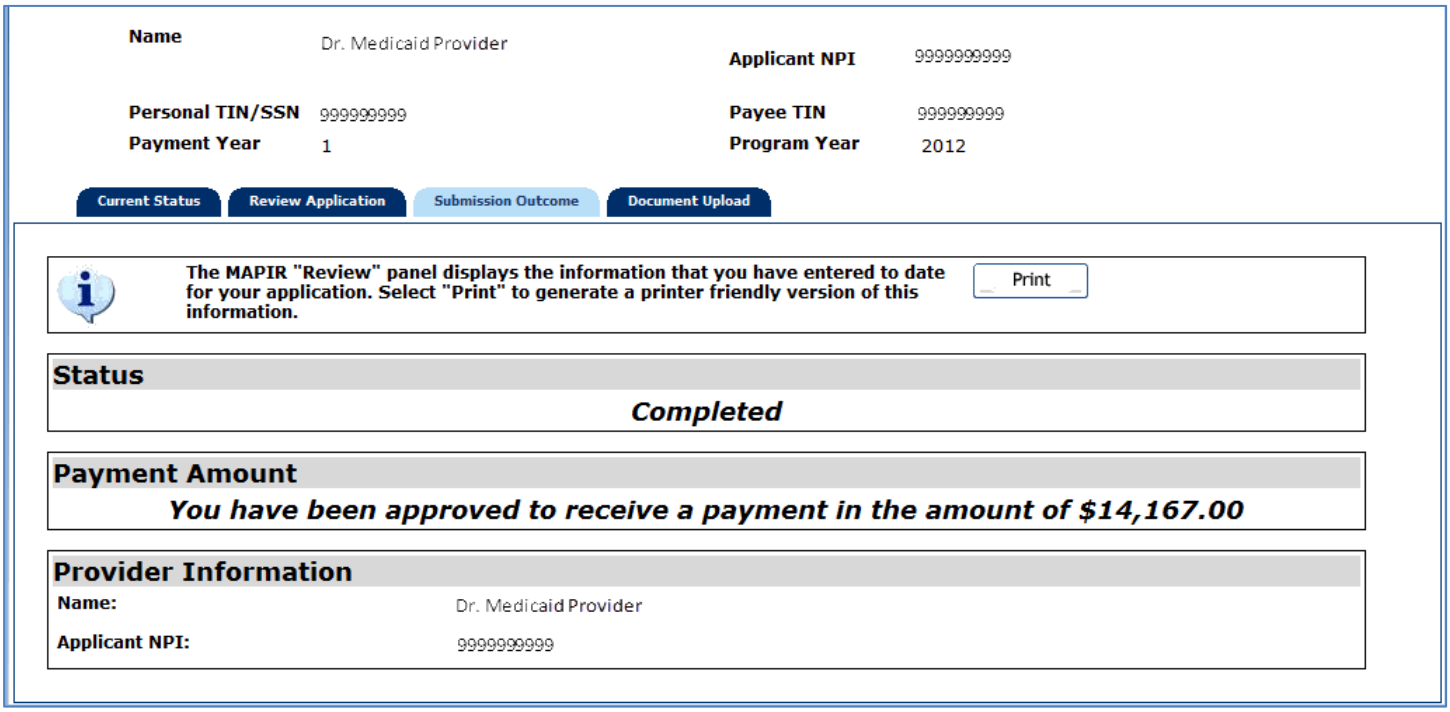
Continue

The screen below shows an application in a status of Completed. You can click the Review Application tab to review your application; however, you will not be able to make changes.

If your application is in a Submitted, Pended for Review, or a Completed status, you will have the option to upload additional documentation on the Document Upload tab; however, if your application is not in one of the statuses previously mentioned, the Document Upload tab will not display.


Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN [redacted]
Payee TIN [redacted]
Payment Year 1
Program Year 2013
Current Status
Review Application
Submission Outcome
Document Upload
Name:
JEREMY MAPIR
Applicant NPI: 2011062801
Status: Completed
Welcome to Connecticut's Medical Assistance Provider Incentive Repository (MAPIR).
A few key points to assist you in navigating MAPIR as you complete the registration process.
Your MAPIR user session ends if there is no user activity longer than 60 minutes. You will receive timeout warnings.
Please note that whoever begins the MAPIR application must be the same person who completes the application.
When a MAPIR electronic tab is completed a check mark will appear in the corner of the tab.
You can go back in the application tabs to review information content but not forward.
Note: You will be able to review and edit all entered information before submitting.

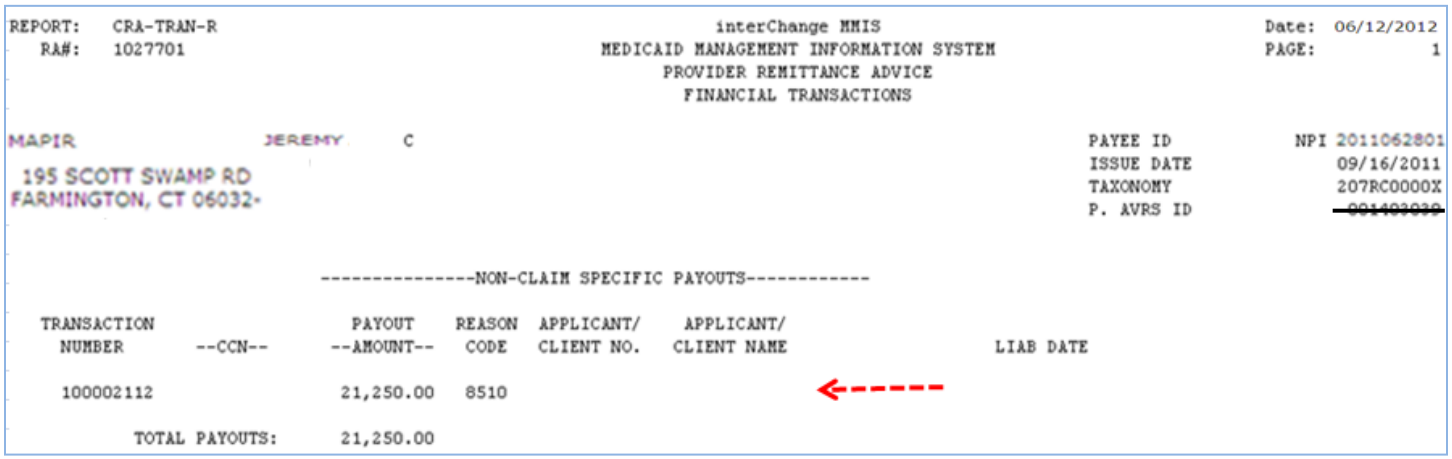
Once your application has been processed by Connecticut Medicaid program office, you can click the **Submission Outcome** tab to view the results of submitting your application.


Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 1
Program Year 2012
Current Status
Review Application
Submission Outcome
Document Upload
The MAPIR "Review" panel displays the information that you have entered to date for your application. Select "Print" to generate a printer friendly version of this information.
Print
Status
Completed
Payment Amount
You have been approved to receive a payment in the amount of $14,167.00
Provider Information
Name: Dr. Medicaid Provider
Applicant NPI: 9999999999

Post Submission – Payment

After the attestation is Payment Approved, payment will be made during the regular financial cycle in 2-4 weeks depending on cut off dates for payment. The financial transaction is reflected under the Payee Provider AVRS ID's Remittance Advice and included in their Electronic Fund Transfer (EFT). The payment will be reflected on the Financial Transaction page under Non-Claim Specific Payouts and the transaction will be identified by a Reason Code of 8510 – Medicaid EHR Incentive Payment.

When the payee ID is the same as the applicant ID, the Applicant Name will not be displayed.



REPORT: CRA-TRAN-R
RA#: 1027701

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

Date: 06/12/2012
PAGE: 1

MAPIR JEREMY C
195 SCOTT SWAMP RD
FARMINGTON, CT 06032-

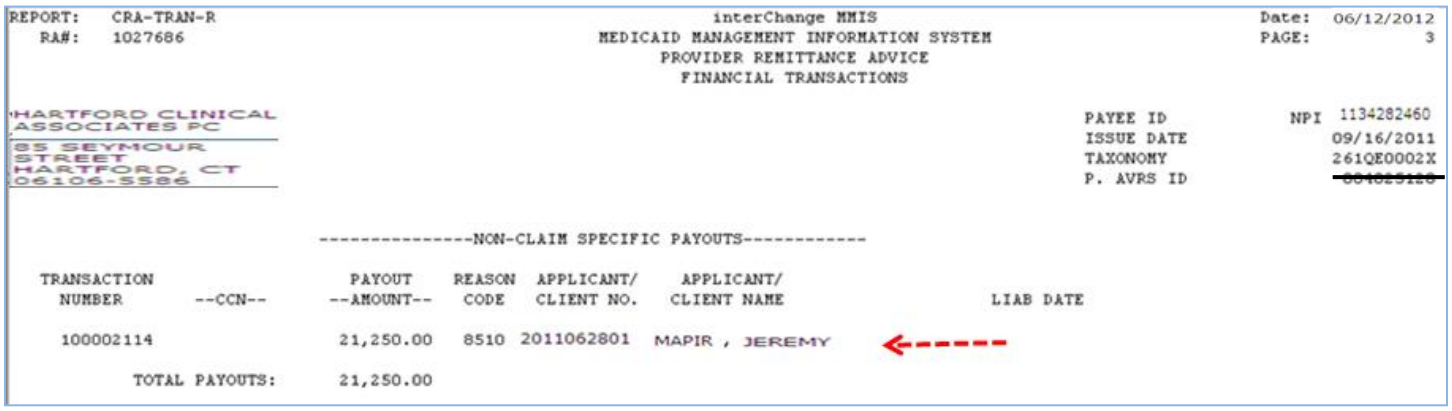
PAYEE ID NPI 2011062801
ISSUE DATE 09/16/2011
TAXONOMY 207RC0000X
P. AVRS ID [redacted]

----------NON-CLAIM SPECIFIC PAYOUTS----------

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
100002112		21,250.00	8510			

TOTAL PAYOUTS: 21,250.00

When the payee ID is different than the applicant ID, the Applicant Name will be displayed.



REPORT: CRA-TRAN-R
RA#: 1027686

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

Date: 06/12/2012
PAGE: 3

HARTFORD CLINICAL ASSOCIATES PC
65 SEYMOUR STREET
HARTFORD, CT 06106-5586

PAYEE ID NPI 1134282460
ISSUE DATE 09/16/2011
TAXONOMY 261QE0002X
P. AVRS ID [redacted]

----------NON-CLAIM SPECIFIC PAYOUTS----------

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
100002114		21,250.00	8510	2011062801	MAPIR , JEREMY	

TOTAL PAYOUTS: 21,250.00

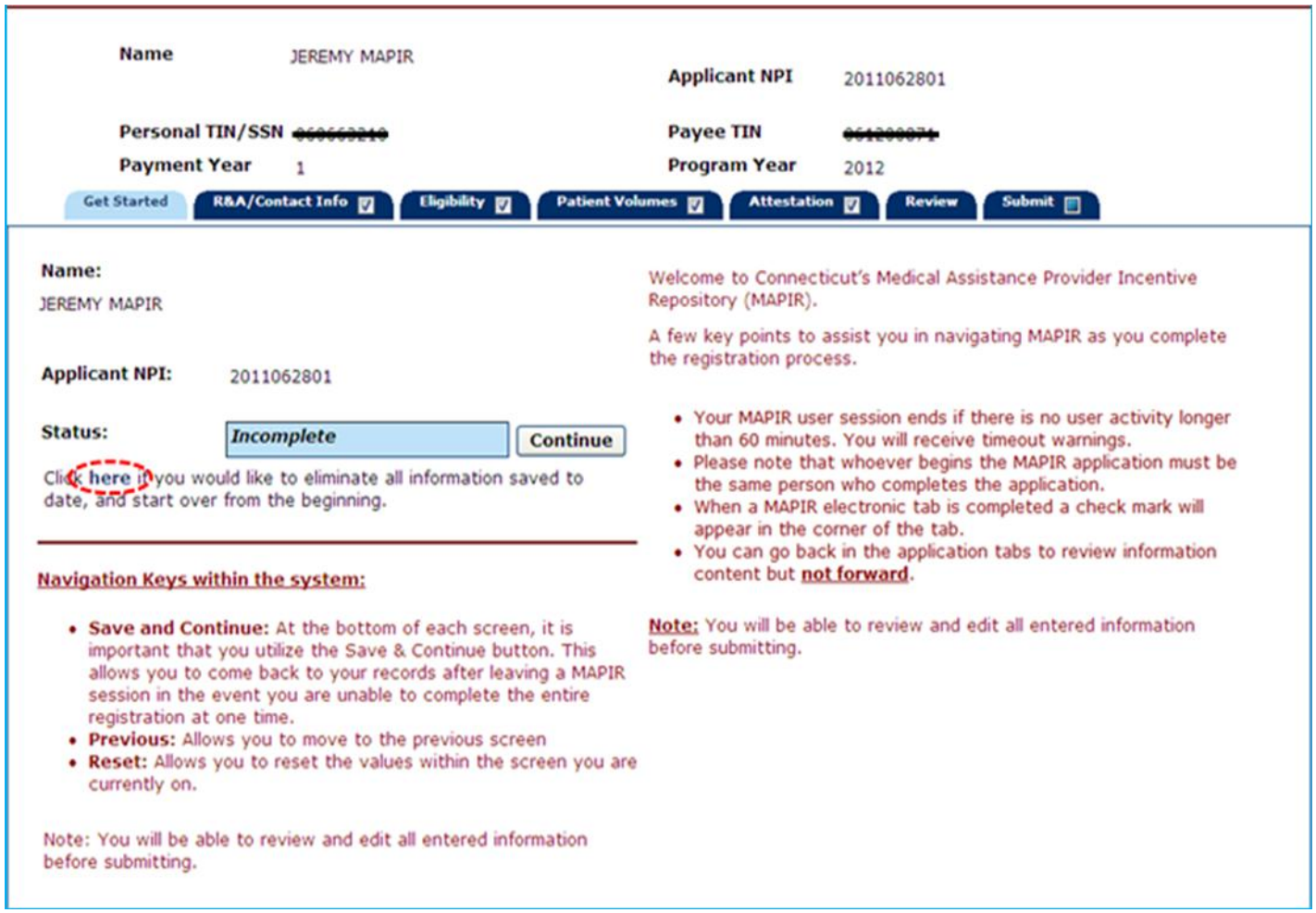
The following table lists some of the statuses your application may go through.

Status	Definition
Not Registered at R&A	MAPIR has not received a matching registration from both the R&A and the state MMIS.
Incomplete	The application is in a working status but has not been submitted and may still be updated by the provider.
Submitted	The application has been submitted. The application is locked to prevent editing and no further changes can be made.
Payment Approved	A determination has been made that the application has been approved for payment.
Payment Disbursed	The financial payment data has been received by MAPIR and will appear on your remittance advice.
Partial Recoupment Received	An adjustment has been requested and the total amount has not been recouped.
Partial Remittance Received	An adjustment has been processed and a partial recoupment has been made and will appear on your remittance advice.
Aborted	When in this status, all progress has been eliminated for the incentive application and the application can no longer be modified or submitted.
Appeal Initiated	An appeal has been lodged with the proper state authority by the provider.
Appeal Approved	The appeal has been approved.
Appeal Denied	The appeal has been denied.
Denied	A determination has been made that the provider does not qualify for an incentive payment based on one or more of the eligibility rules.
Completed	The application has run a full standard process and completed successfully with a payment to the provider.
Cancelled	An application has been set to "Cancelled" status only when R&A communicates a registration cancellation to MAPIR. MAPIR cancels both the registration and any associated application.
Future	This is a status that will be displayed against any application to indicate the number of future applications that the provider can apply for within the EHR Incentive Program.
Not Eligible	This is a status that will be displayed against any application whenever the provider has exceeded the limits of the program timeframe.
Not Started	This is a status that will be displayed against any application whenever the provider has not started an application but MAPIR received an R&A registration and has been matched to an MMIS provider.
Expired	An application is set to an "Expired" status when an application in an "Incomplete" status has not been submitted within the allowable grace period for a program year or when an authorized admin user changes an application to this status after the end of the grace period. Once an application is in an Expired status, the status cannot be changed and it is only viewable to the provider.

Additional User Information

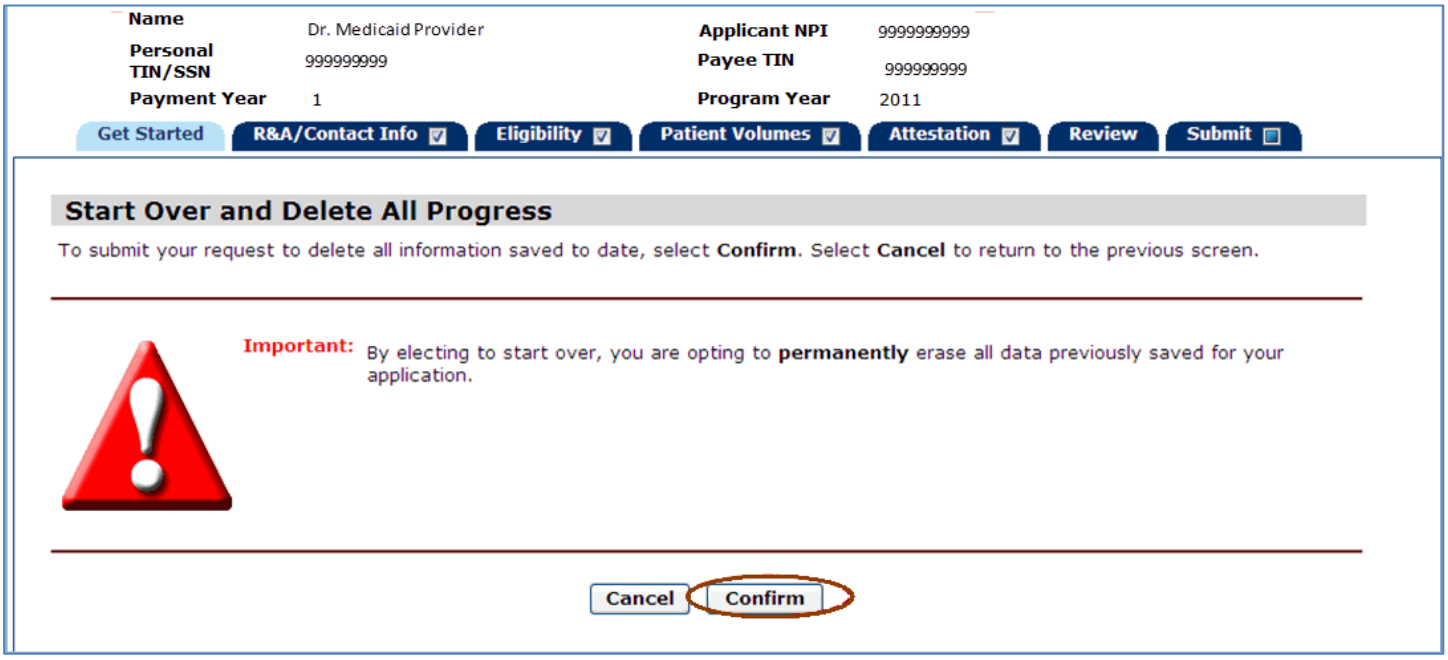
This section contains an explanation of informational messages, system error messages, and validation messages you may receive.

Start Over and Delete All Progress - If you would like to start your application over from the beginning you can click the Get Started tab. Click the here link on the screen to start over from the beginning. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

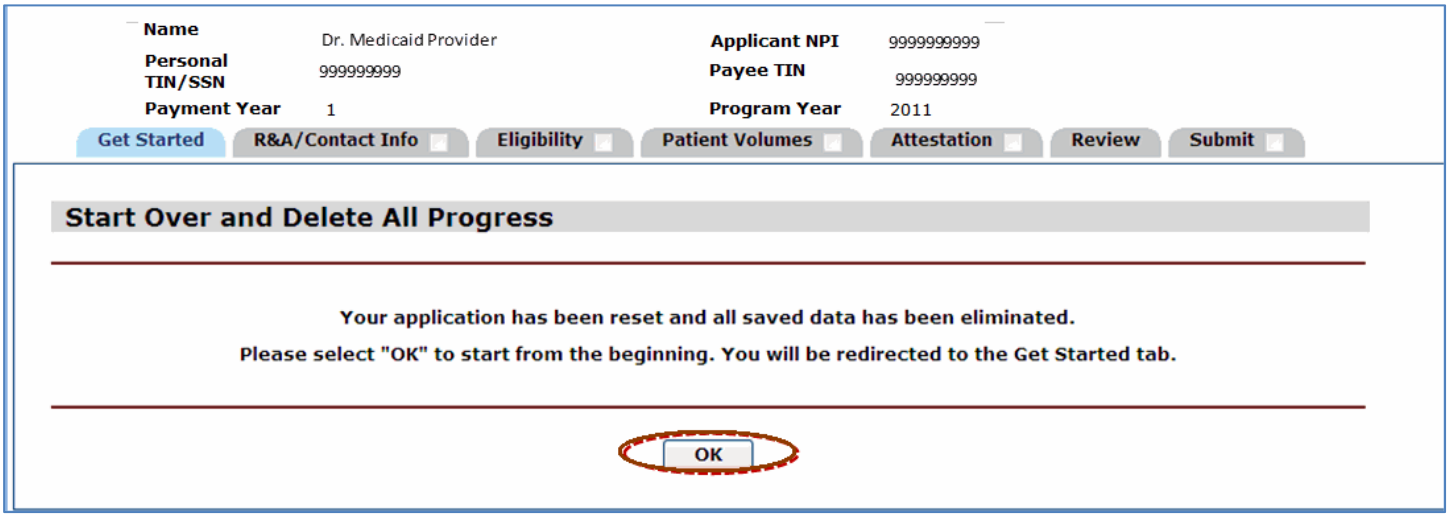

Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN
Payee TIN
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Name:
JEREMY MAPIR
Applicant NPI: 2011062801
Status: Incomplete
Continue
Click here if you would like to eliminate all information saved to date, and start over from the beginning.
Navigation Keys within the system:
Save and Continue: At the bottom of each screen, it is important that you utilize the Save & Continue button. This allows you to come back to your records after leaving a MAPIR session in the event you are unable to complete the entire registration at one time.
Previous: Allows you to move to the previous screen
Reset: Allows you to reset the values within the screen you are currently on.
Note: You will be able to review and edit all entered information before submitting.
Welcome to Connecticut's Medical Assistance Provider Incentive Repository (MAPIR).
A few key points to assist you in navigating MAPIR as you complete the registration process.
Your MAPIR user session ends if there is no user activity longer than 60 minutes. You will receive timeout warnings.
Please note that whoever begins the MAPIR application must be the same person who completes the application.
When a MAPIR electronic tab is completed a check mark will appear in the corner of the tab.
You can go back in the application tabs to review information content but not forward.
Note: You will be able to review and edit all entered information before submitting.

This screen will confirm your selection to start the application over and delete all information saved to date. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

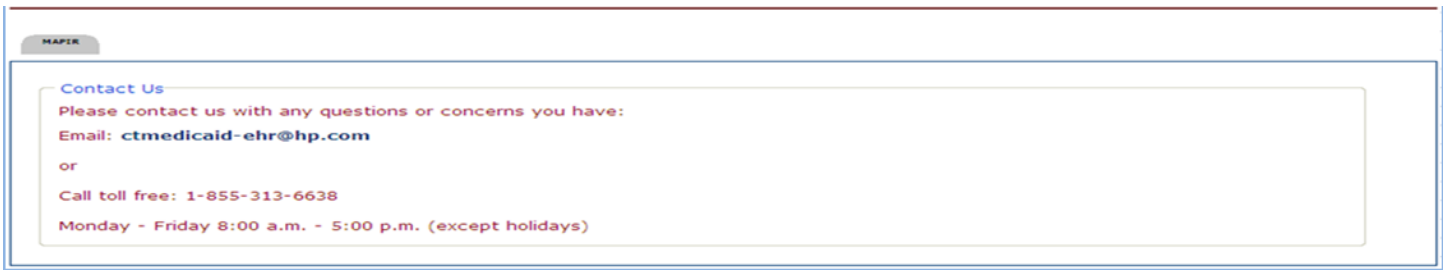
Click **Confirm** to Start Over and Delete All Progress.



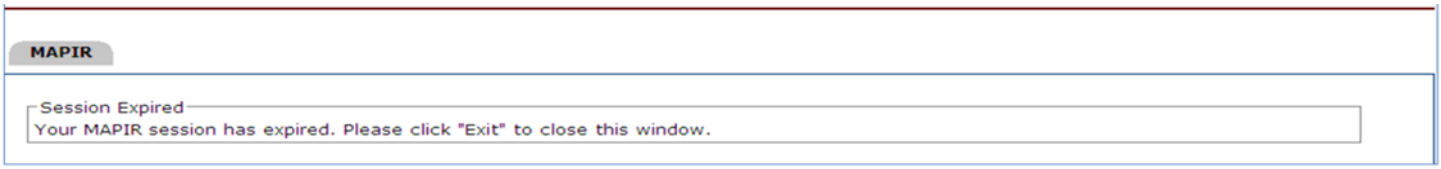
If you clicked **Confirm** you will receive the following confirmation message. Click **OK** to continue.



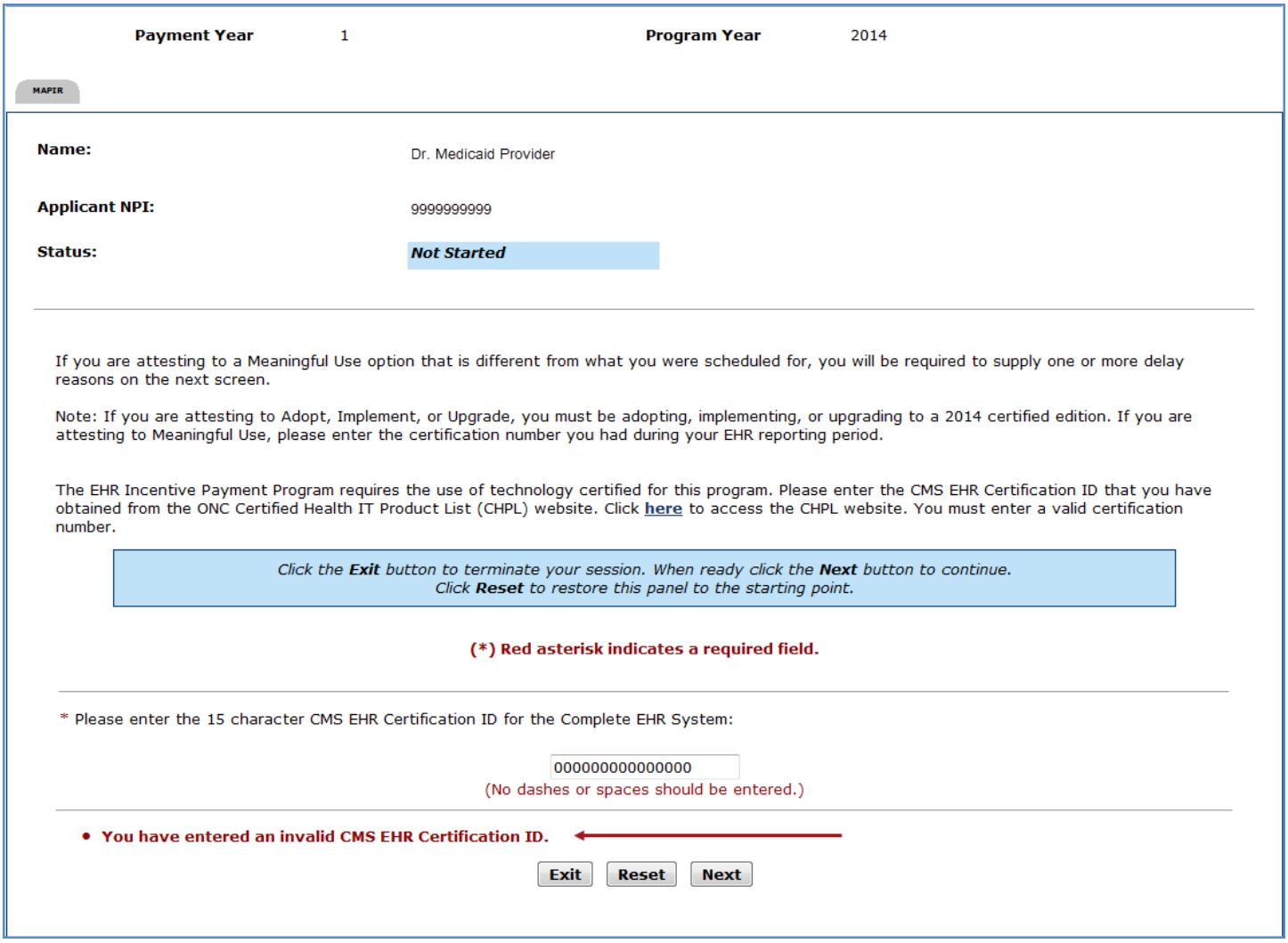
Contact Us – Clicking on the Contact Us link in the upper right corner of most screens within MAPIR will display the following state Medicaid program contact information.


MAPIR
Contact Us
Please contact us with any questions or concerns you have:
Email: ctmedicaid-ehr@hp.com
or
Call toll free: 1-855-313-6638
Monday - Friday 8:00 a.m. - 5:00 p.m. (except holidays)

MAPIR Error Message –This screen will appear when a MAPIR error has occurred. Follow all instructions on the screen. Click **Exit** to exit MAPIR.



Validation Messages –The following is an example of the validation message – You have entered an invalid CMS EHR Certification ID. Check and reenter your CMS EHR Certification ID. The Validation Messages Table lists validation messages you may receive while using MAPIR.


Payment Year 1
Program Year 2014
MAPIR
Name:
Dr. Medicaid Provider
Applicant NPI:
9999999999
Status:
Not Started
If you are attesting to a Meaningful Use option that is different from what you were scheduled for, you will be required to supply one or more delay reasons on the next screen.
Note: If you are attesting to Adopt, Implement, or Upgrade, you must be adopting, implementing, or upgrading to a 2014 certified edition. If you are attesting to Meaningful Use, please enter the certification number you had during your EHR reporting period.
The EHR Incentive Payment Program requires the use of technology certified for this program. Please enter the CMS EHR Certification ID that you have obtained from the ONC Certified Health IT Product List (CHPL) website. Click here to access the CHPL website. You must enter a valid certification number.
Click the Exit button to terminate your session. When ready click the Next button to continue.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Please enter the 15 character CMS EHR Certification ID for the Complete EHR System:
000000000000000
(No dashes or spaces should be entered.)
• You have entered an invalid CMS EHR Certification ID.
Exit
Reset
Next

Validation Messages Table

Validation Messages
Please enter all required information.
You must provide all required information in order to proceed.
Please correct the information at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A).
The date that you have specified is invalid, or occurs prior to the program eligibility.
The date that you have specified is invalid.
The phone number that you entered is invalid.
The phone number must be numeric.
The email that you entered is invalid.
As a Hospital based physician, you are not eligible to participate.
You must participate in the Medicaid incentive program in order to qualify.
You must select at least one type of provider.
You must select at least one location in order to proceed.
The ZIP Code that you entered is invalid.
You must select at least one activity in order to proceed.
You must define all added 'Other' activities.
Amount must be numeric.
You must indicate whether you are completing this application as the actual provider or a preparer.
You must verify that you have reviewed all information entered into MAPIR.
Please confirm. You must not have any current sanctions or pending sanctions with Medicare or Medicaid in order to qualify.
You did not meet the criteria to receive the incentive payment.
All data must be numeric.
You must enter all requested information in order to submit the application.
The email address you have entered does not match.
You have entered an invalid CMS EHR Certification ID.
You must be licensed in the state(s) in which you practice.
You must select Yes or No to utilizing certified EHR technology in this location.
You have entered a duplicate Group Practice Provider ID.
You must select a Payment Address in order to proceed.
You must enter the email address twice for validation purposes.
You must be in compliance with HIPAA regulations.
All amounts must be between 0 and 999,999,999,999,999.
Numerator cannot be greater than denominator and numerator/denominator cannot be a negative value.
You must answer Yes to utilizing certified EHR technology in at least one location in order to proceed.
You must exit MAPIR and return, in order to access a different program year incentive application.
You must choose an application
The amounts entered are invalid.

Validation Messages
You may only select yes to one exclusion.
The Start Date you have entered was attested to in a previous Payment Year.
You have not met the minimum number of documents required. Please upload the minimum number of documents required to proceed.
File must be in Excel, Word or PDF format.
File must be no larger than 5 Mega Bytes (MB).
You may not exclude both Menu Measures 9 & 10.
You may not attest to Menu Measure 9 and exclude Menu Measure 10.
You many not exclude Menu Measure 9 and attest to Menu Measure 10.
You must select a minimum of 9 Clinical Quality Measures from at least 3 different Domains to proceed.
You must select all menu measures when an exclusion has been claimed on one or more menu measures.
The Performance Rate value you entered is invalid, it must be a combination of a whole number and a decimal (for example, “10.0”). The acceptable range for Performance Rate value is 0.0 to 100.0.
The Observation percent value you entered is invalid, it must be a combination of a whole number and a decimal (for example, "10.0"). The acceptable range for Observation percent value is 0.0 to 100.0.
Full Year is not a valid option for Program Year 2014. Please select the 90 day option.
You have excluded both Public Health measures. Please select 5 Menu measures from outside the Public Health Menu set.
You have selected to exclude a Public Health measure. Please attest to the remaining Public Health measure.
The Patient Volume 90 day date range is no longer valid.
Delay reason must be 500 characters or less.
ONC Service is unavailable
You have entered an invalid CMS EHR Certification ID for the current “Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology Rule"

Acronyms and Terms

CHIP – Children's Health Insurance Program

CHPL – ONC Certified Healthcare IT Product List

CMS – Center for Medicare and Medicaid Services

EH – Eligible Hospital

EHR –Electronic Health Record

EP – Eligible Professional

FQHC/RHC – Federally Qualified Health Center/Rural Health Clinic

MAPIR – Medical Assistance Provider Incentive Repository

NPI – National Provider Identifier

ONC – Office of the National Coordinator for Health Information Technology

Program Switch Incentive Application - The first incentive application from an EP that has switched from Medicare to Medicaid or from Medicaid to Medicare.

R&A – CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System

State-To-State Switch Incentive Application – The first incentive application from an EP that has switched from one state to another

TIN – Taxpayer Identification Number

Program Year 2014

This section provides instructions for the steps of the incentive application process that differ for a Program Year 2014 incentive application than a Program Year 2015 incentive application.

For a Program Year 2014 incentive application, you will have to select a Meaningful Use Reporting option, as displayed on the screen on the following page. The options available to you will depend on the CMS EHR Certification ID and stage progression. The table below identifies the Meaningful Use Reporting options available for Program Year 2014.

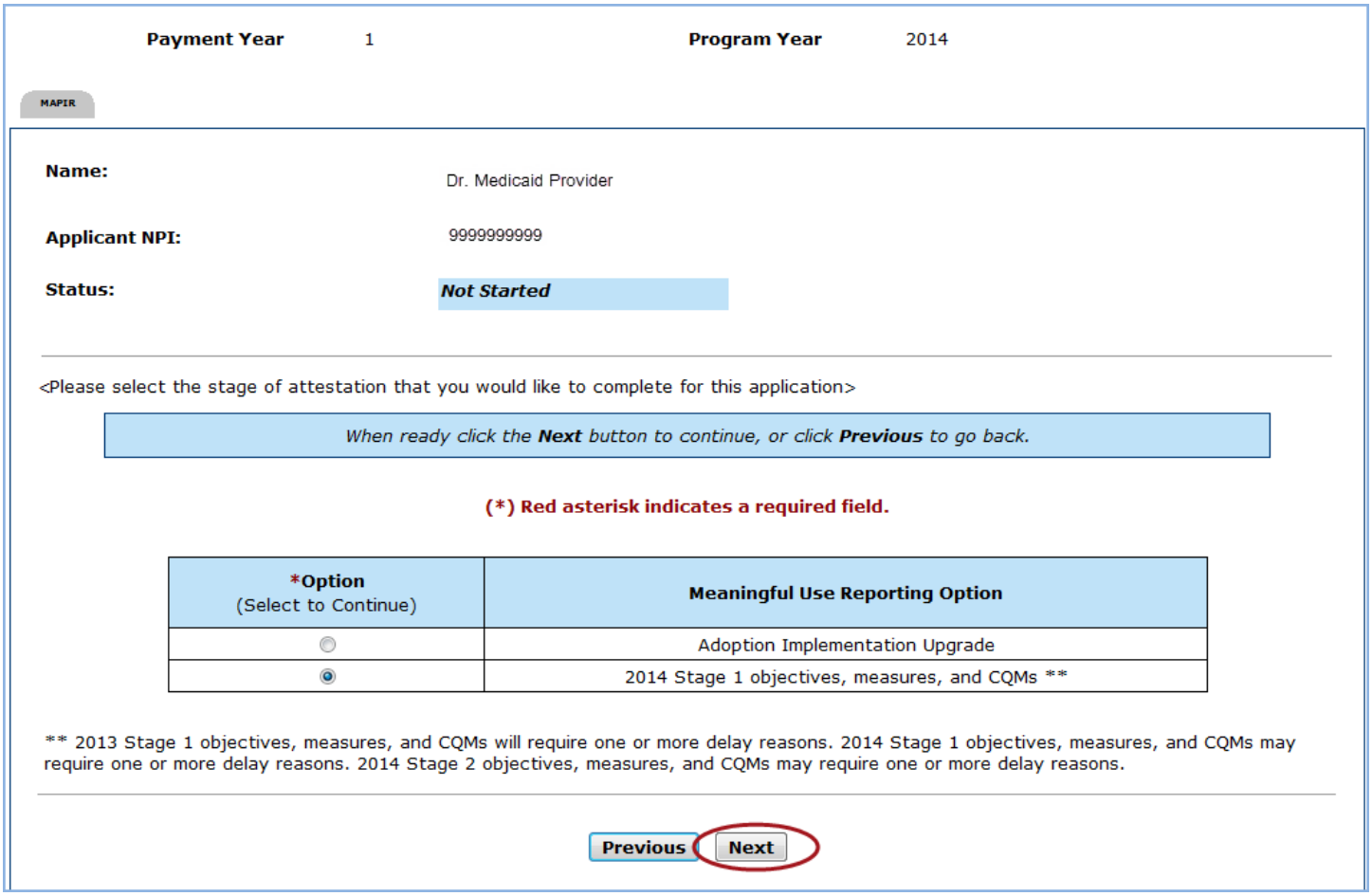
Program Year 2014 Meaningful Use Reporting Options		
CMS EHR Certification ID	**Stage Progression**	**Meaningful Use Reporting Option**
2011	All payment years	2013 Stage 1 objectives, measures, and CQMs
2011/2014	First or second year attesting to Meaningful Use.	2013 Stage 1 objectives, measures, and CQMs 2014 Stage 1 objectives, measures, and CQMs
2011/2014	Third year attesting to Meaningful Use.	2013 Stage 1 objectives, measures, and CQMs 2014 Stage 1 objectives, measures, and CQMs 2014 Stage 2 objectives, measures, and CQMs
2014	Payment Year 1	AIU 2014 Stage 1 objectives, measures, and CQMs.
2014	Payment Year 2	2014 Stage 1 objectives, measures, and CQMs
2014	Third year attesting to Meaningful Use.	2014 Stage 1 objectives, measures, and CQMs 2014 Stage 2 objectives, measures, and CQMs

Depending the Meaningful Use Reporting option that you select, you may be required to enter a delay reason.

The Program Year 2014 Meaningful Use reporting options only apply to new incentive application or incentive applications that are aborted and re-started after the implementation of MAPIR Release 5.5.

Meaningful Use Reporting Option

Select the stage of attestation that you would like to complete for this incentive application. Click **Next** to continue.

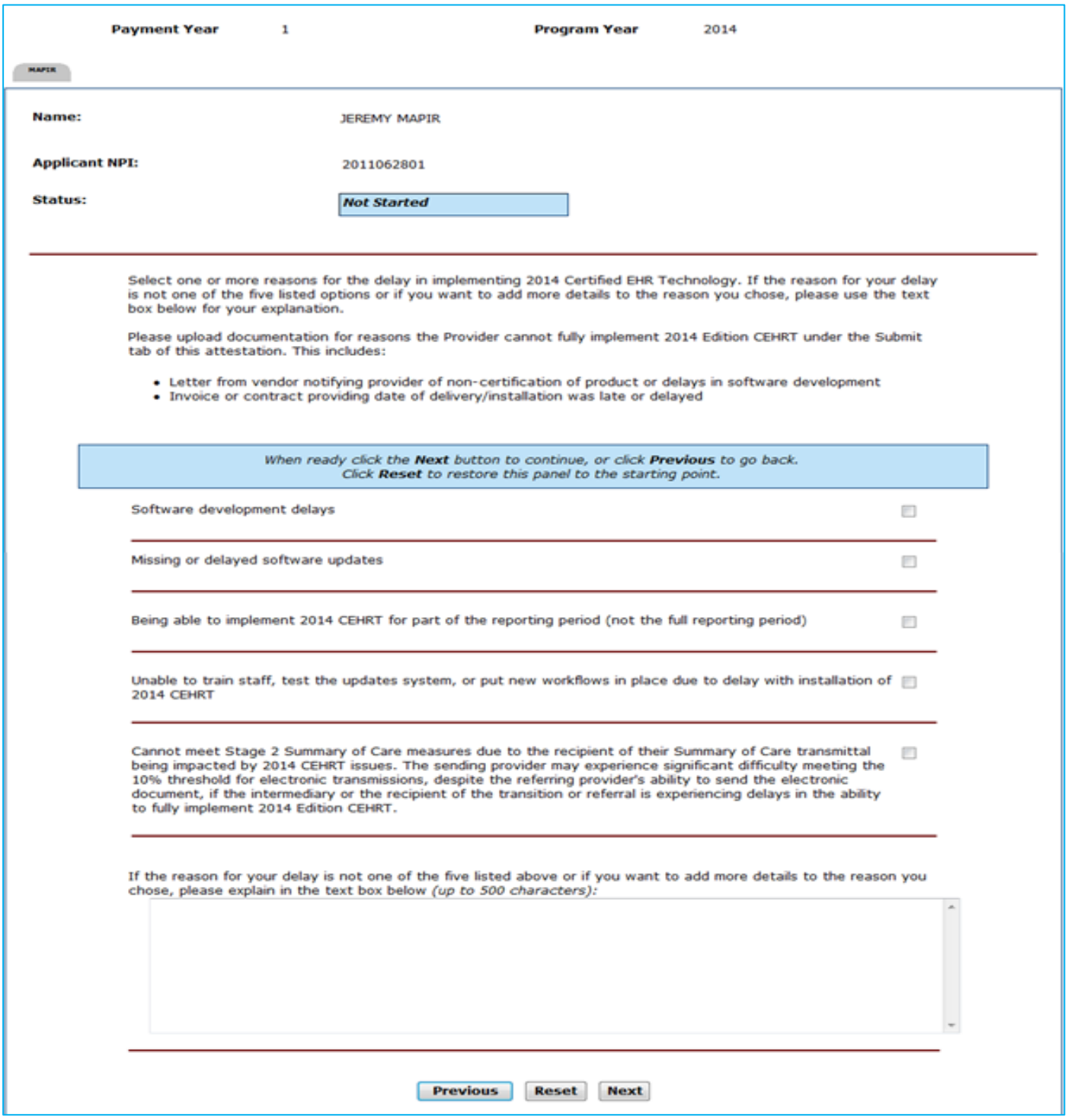


If the stage of attestation that you selected does not require a delay reason, proceed to page 208.

If the stage of attestation that you selected requires a delay reason, the following screen will display.

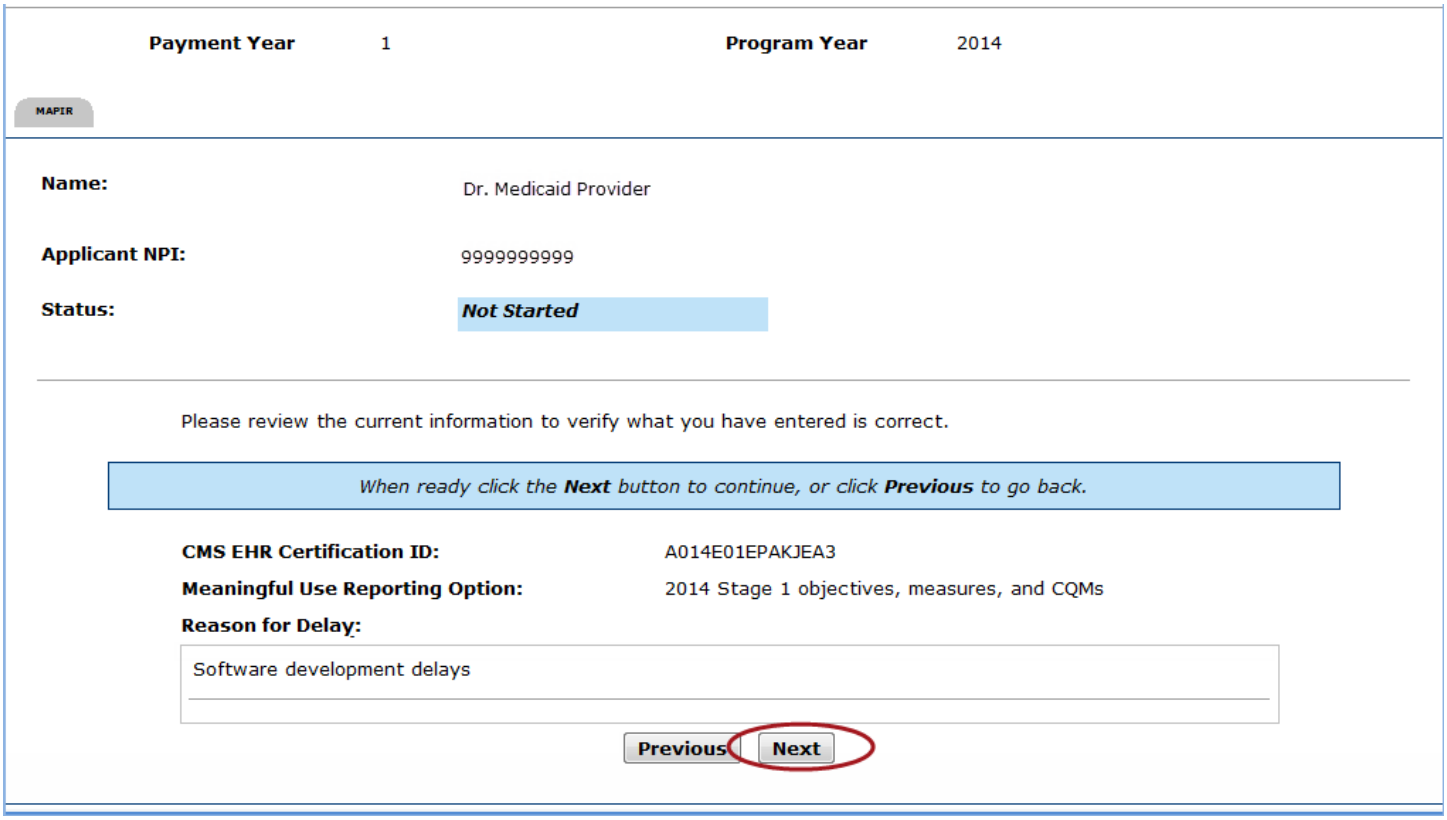
Select one or more reason for the delay in implementing 2014 Certified EHR Technology. If your reason for delay is not listed or you would like to add more details to the reason you chose, use the text box below the list of delay reasons. You will be required to upload documentation supporting the reason(s) for delay under the Submit tab of the attestation.

Click **Next** to review your entry. Click **Previous** to return to the stage of attestation selection page. Click **Reset** to restore this panel back to the starting point.


Payment Year 1
Program Year 2014
MAPIR
Name: JEREMY MAPIR
Applicant NPI: 2011062801
Status: Not Started
Select one or more reasons for the delay in implementing 2014 Certified EHR Technology. If the reason for your delay is not one of the five listed options or if you want to add more details to the reason you chose, please use the text box below for your explanation.
Please upload documentation for reasons the Provider cannot fully implement 2014 Edition CEHRT under the Submit tab of this attestation. This includes:
Letter from vendor notifying provider of non-certification of product or delays in software development
Invoice or contract providing date of delivery/installation was late or delayed
When ready click the Next button to continue, or click Previous to go back.
Click Reset to restore this panel to the starting point.
Software development delays
Missing or delayed software updates
Being able to implement 2014 CEHRT for part of the reporting period (not the full reporting period)
Unable to train staff, test the updates system, or put new workflows in place due to delay with installation of 2014 CEHRT
Cannot meet Stage 2 Summary of Care measures due to the recipient of their Summary of Care transmittal being impacted by 2014 CEHRT issues. The sending provider may experience significant difficulty meeting the 10% threshold for electronic transmissions, despite the referring provider's ability to send the electronic document, if the intermediary or the recipient of the transition or referral is experiencing delays in the ability to fully implement 2014 Edition CEHRT.
If the reason for your delay is not one of the five listed above or if you want to add more details to the reason you chose, please explain in the text box below (up to 500 characters):
Previous
Reset
Next

Review your CMS EHR Certification ID, Meaningful Use Reporting Option, and Reason for Delay (if applicable). Click **Next** to continue, or click **Previous** to go back.

If you were not required to enter a delay reason, the Reason for Delay field will be blank.



Proceed to page 26 of this guide.

2013 Stage 1 objectives, measures, and CQM

The screen on the following page displays the Measures Topic List. The Attestation Meaningful Use Measures are divided into six distinct topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, Alternate Core Clinical Quality Measures, and Additional Clinical Quality Measures.

You may select any of the six topics and complete them in any order. You are not required to complete any of the Alternate Core Clinical Quality Measures unless you have entered a zero denominator for one or more Core Clinical Quality Measures.

While it is not required that you begin each topic in the order shown on the screen, this user guide will follow the order in which the topics are listed.

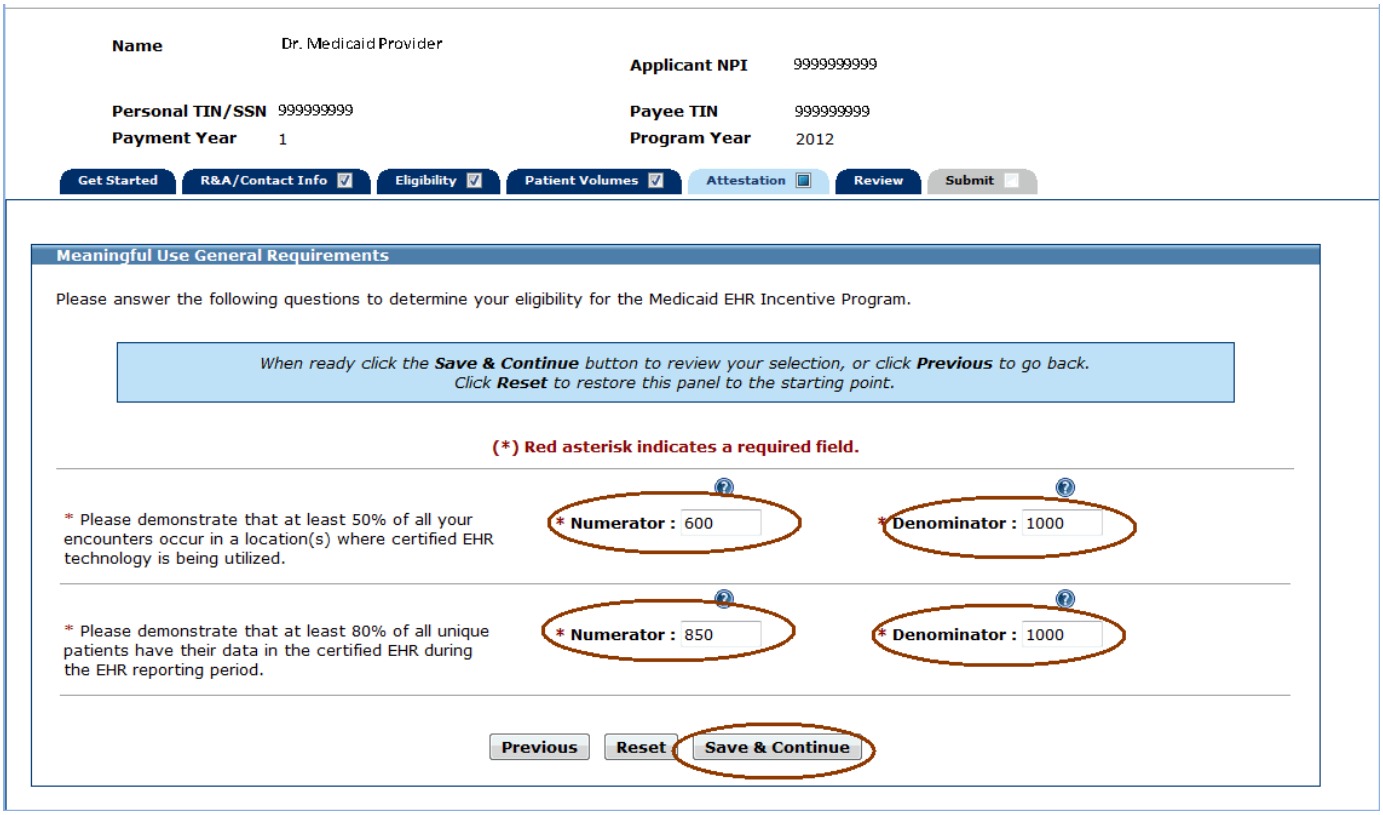
Click **Begin** to start a topic.

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
Begin
Core Measures
Begin
Menu Measures
Begin
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all the of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures
Begin
Alternate Core Clinical Quality Measures
Begin
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use General Requirements

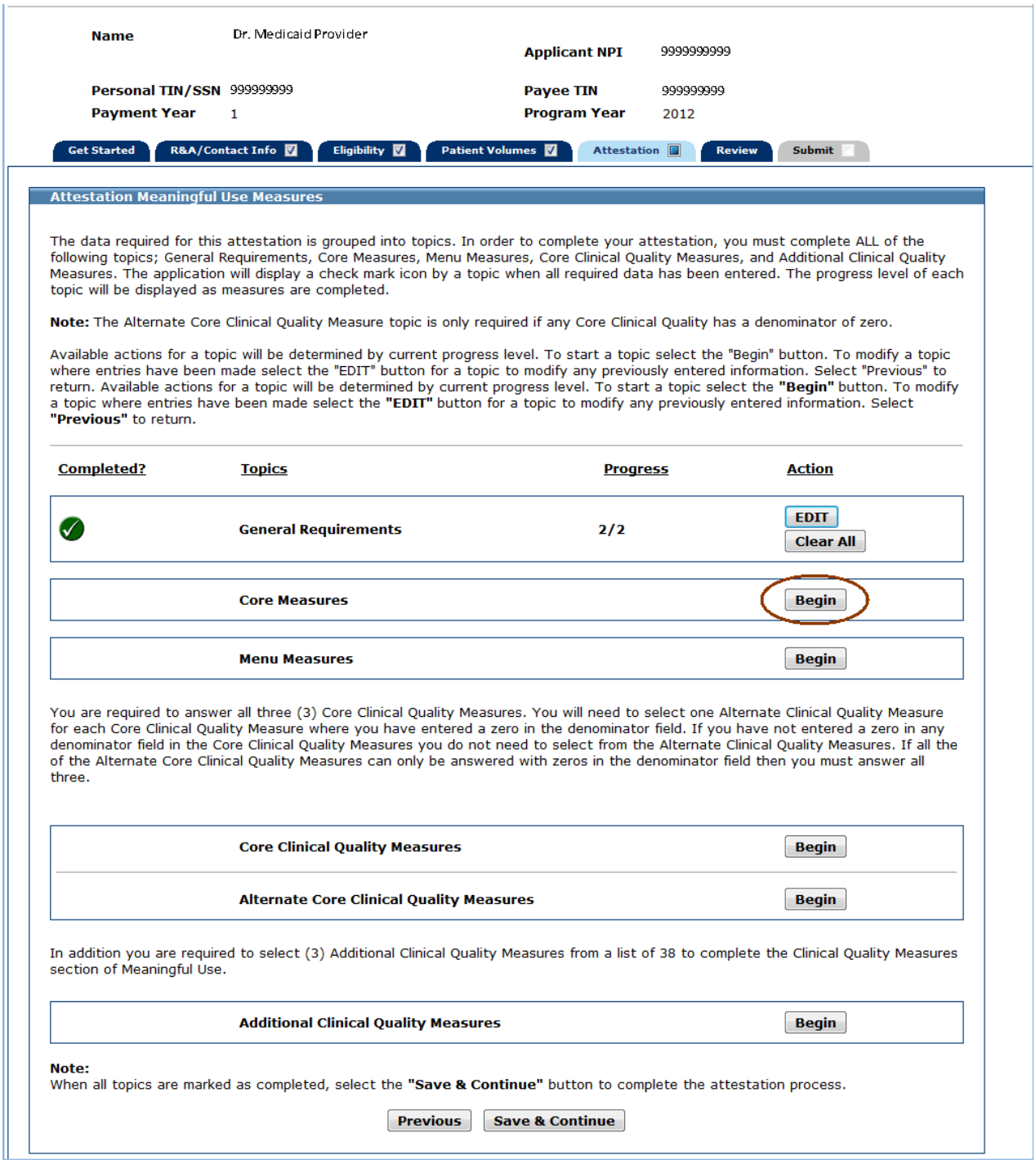
Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Meaningful Use General Requirements
Please answer the following questions to determine your eligibility for the Medicaid EHR Incentive Program.
When ready click the Save & Continue button to review your selection, or click Previous to go back.
Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
* Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.
* Numerator : 600
* Denominator : 1000
* Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.
* Numerator : 850
* Denominator : 1000
Previous
Reset
Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

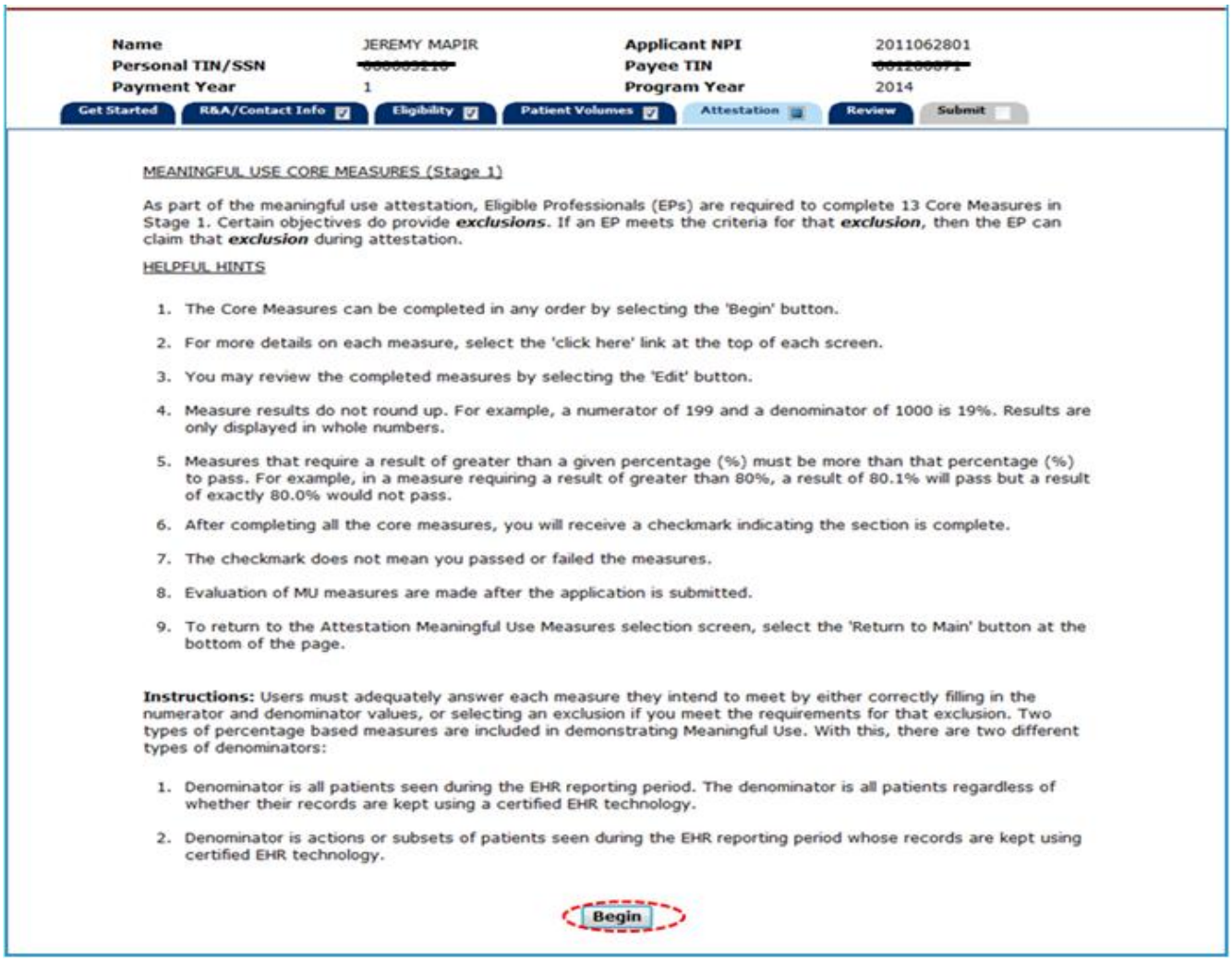
Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return. Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
Begin
Menu Measures
Begin
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all the of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures
Begin
Alternate Core Clinical Quality Measures
Begin
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Core Measures

This screen provides information about the Meaningful Use Core Measures.

Click **Begin** to continue to the Meaningful Use Core Measure List Table.

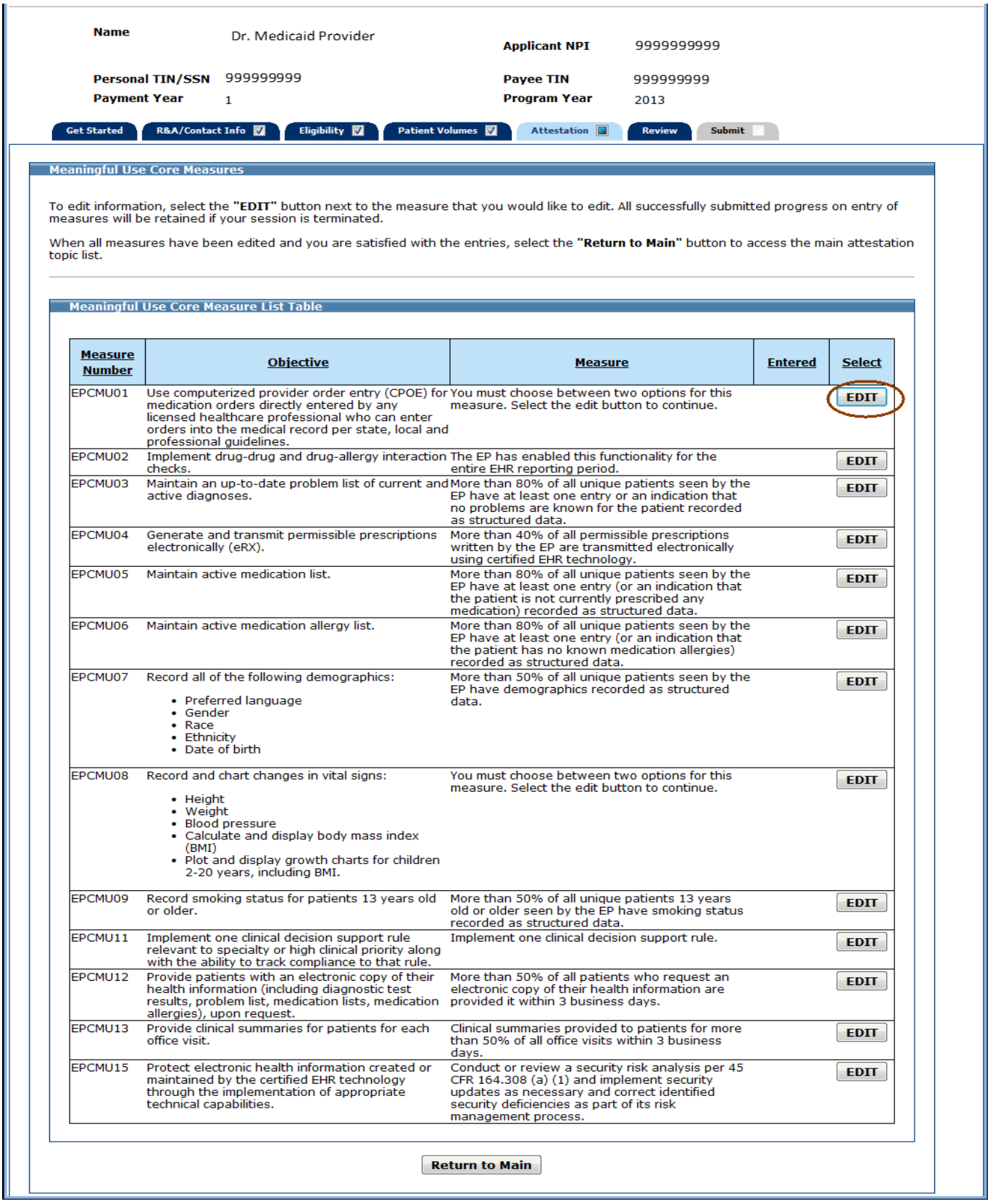

Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE CORE MEASURES (Stage 1)
As part of the meaningful use attestation, Eligible Professionals (EPs) are required to complete 13 Core Measures in Stage 1. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation.
HELPFUL HINTS
1. The Core Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.1% will pass but a result of exactly 80.0% would not pass.
6. After completing all the core measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Instructions: Users must adequately answer each measure they intend to meet by either correctly filling in the numerator and denominator values, or selecting an exclusion if you meet the requirements for that exclusion. Two types of percentage based measures are included in demonstrating Meaningful Use. With this, there are two different types of denominators:
1. Denominator is all patients seen during the EHR reporting period. The denominator is all patients regardless of whether their records are kept using a certified EHR technology.
2. Denominator is actions or subsets of patients seen during the EHR reporting period whose records are kept using certified EHR technology.
Begin

The screen on the following page displays the Meaningful Use Core Measure List Table.

The first time a topic is accessed you will see an **Edit** option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return to Main** to return to the Measures Topic List.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2013

Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

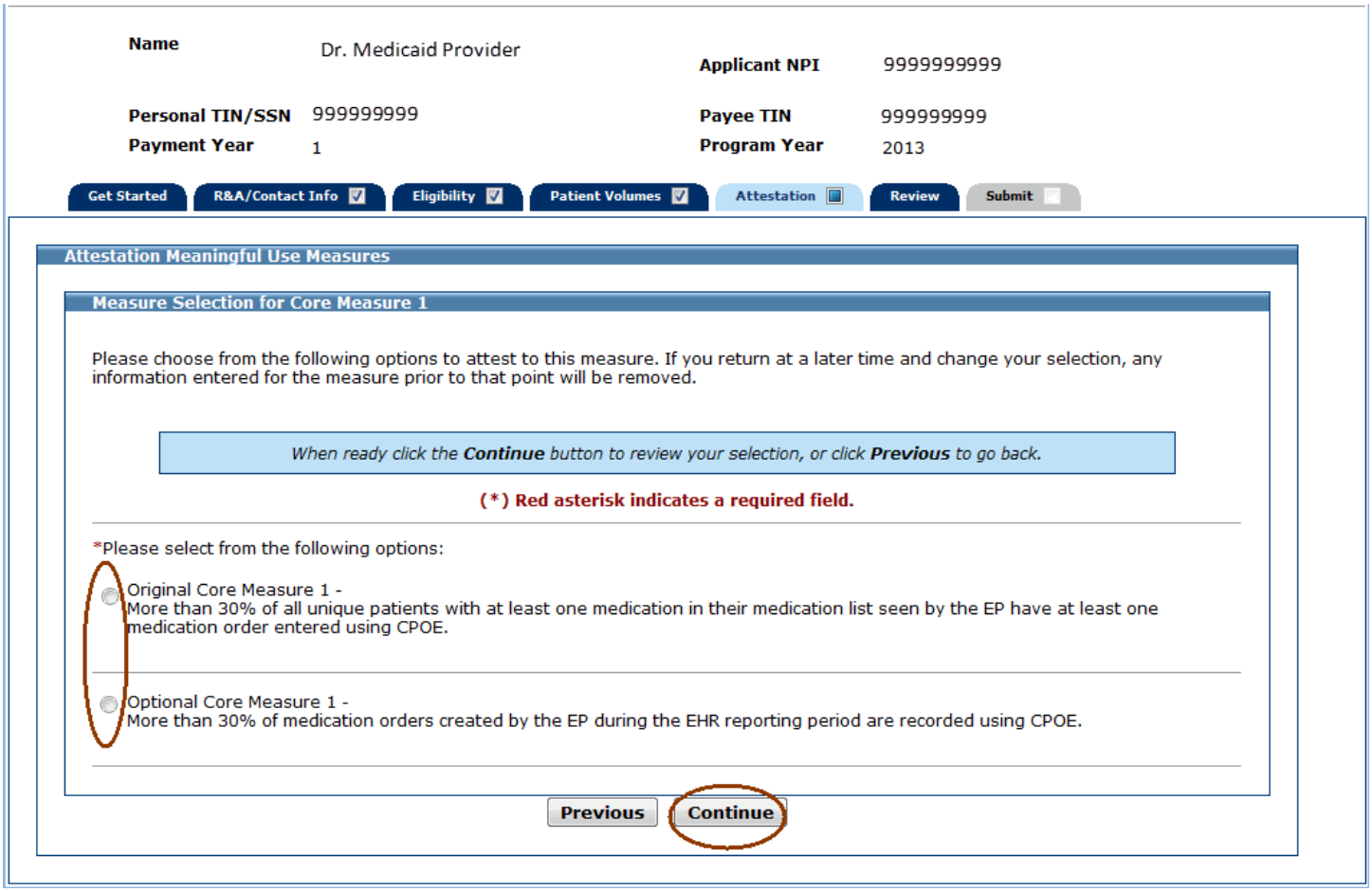
Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.		EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.		EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.		EDIT
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.		EDIT
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.		EDIT
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.		EDIT
EPCMU08	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children 2-20 years, including BMI.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.		EDIT
EPCMU11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.		EDIT
EPCMU12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.		EDIT
EPCMU13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.		EDIT
EPCMU15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.		EDIT

Return to Main

Measure Selection for Core Measure 1 (Measure Code EPCMU01)

Choose if you would like to attest to the **Original Core Measure 1** or the **Optional Core Measure 1**. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

Click **Save & Continue** to proceed to the appropriate core measure screen for the option you selected or click **Previous** to go back


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Measure Selection for Core Measure 1
Please choose from the following options to attest to this measure. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.
When ready click the Continue button to review your selection, or click Previous to go back.
(*) Red asterisk indicates a required field.
*Please select from the following options:
Original Core Measure 1 -
More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Optional Core Measure 1 -
More than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
Previous
Continue

The following is a list of the 13 Meaningful Use Core Measures that you must attest to (Core Measure 1 and Core Measure 8 have two versions to choose from).

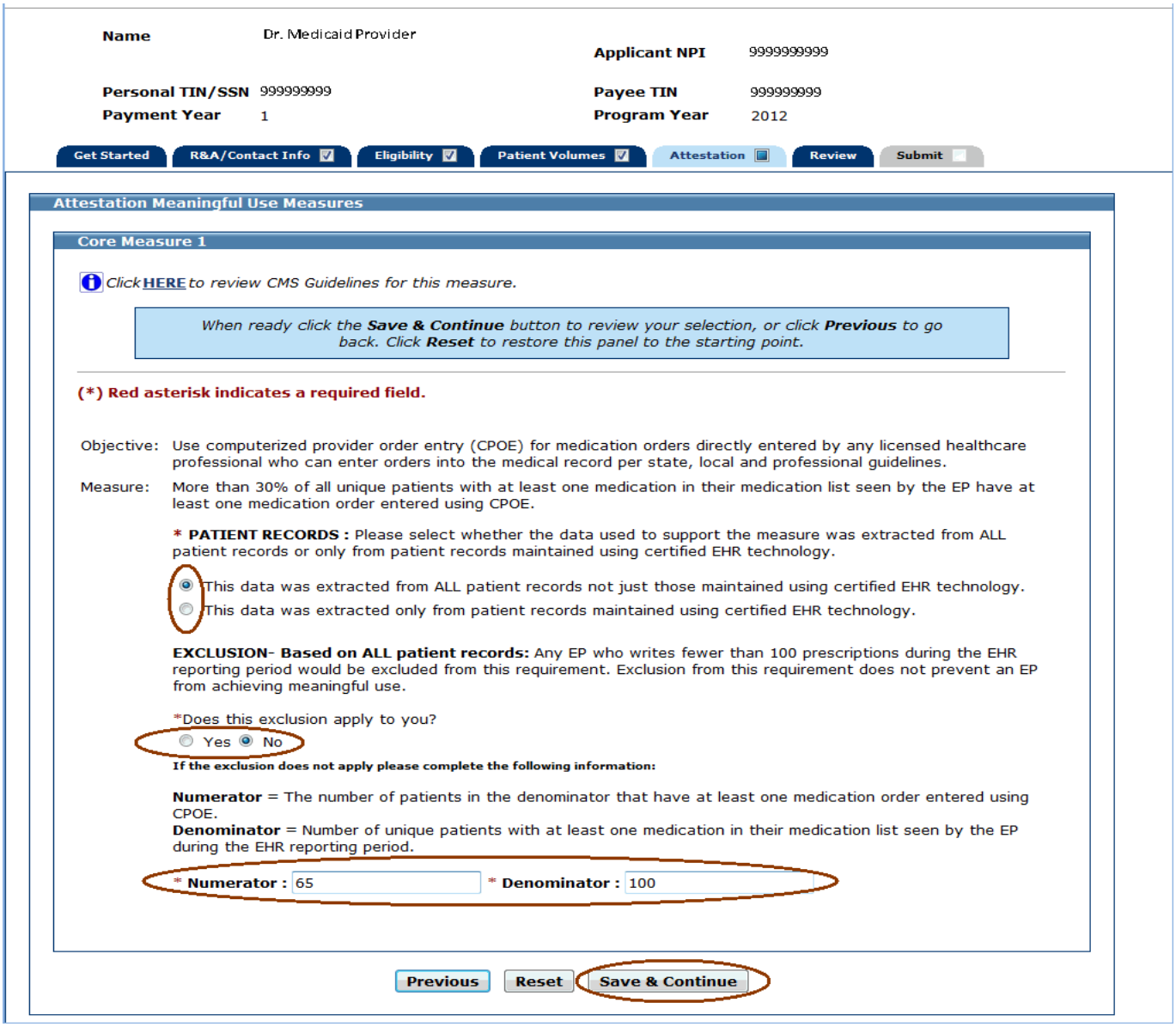
Click on the Screen Example to see an example of the screen layout.

Meaningful Use Core Measure	Screen Example
Core Measure 1 Original	Screen 1
Core Measure 1 Optional	Screen 1
Core Measure 2	Screen 2
Core Measure 3	Screen 3
Core Measure 4	Screen 4
Core Measure 5	Screen 3
Core Measure 6	Screen 3
Core Measure 7	Screen 3
Core Measure 8 Original	Screen 5
Core Measure 8 Optional	Screen 4
Core Measure 9	Screen 1
Core Measure 11	Screen 2
Core Measure 12	Screen 1
Core Measure 13	Screen 1
Core Measure 15	Screen 2

Screen 1

The following Meaningful Use Core Measures use this screen layout:

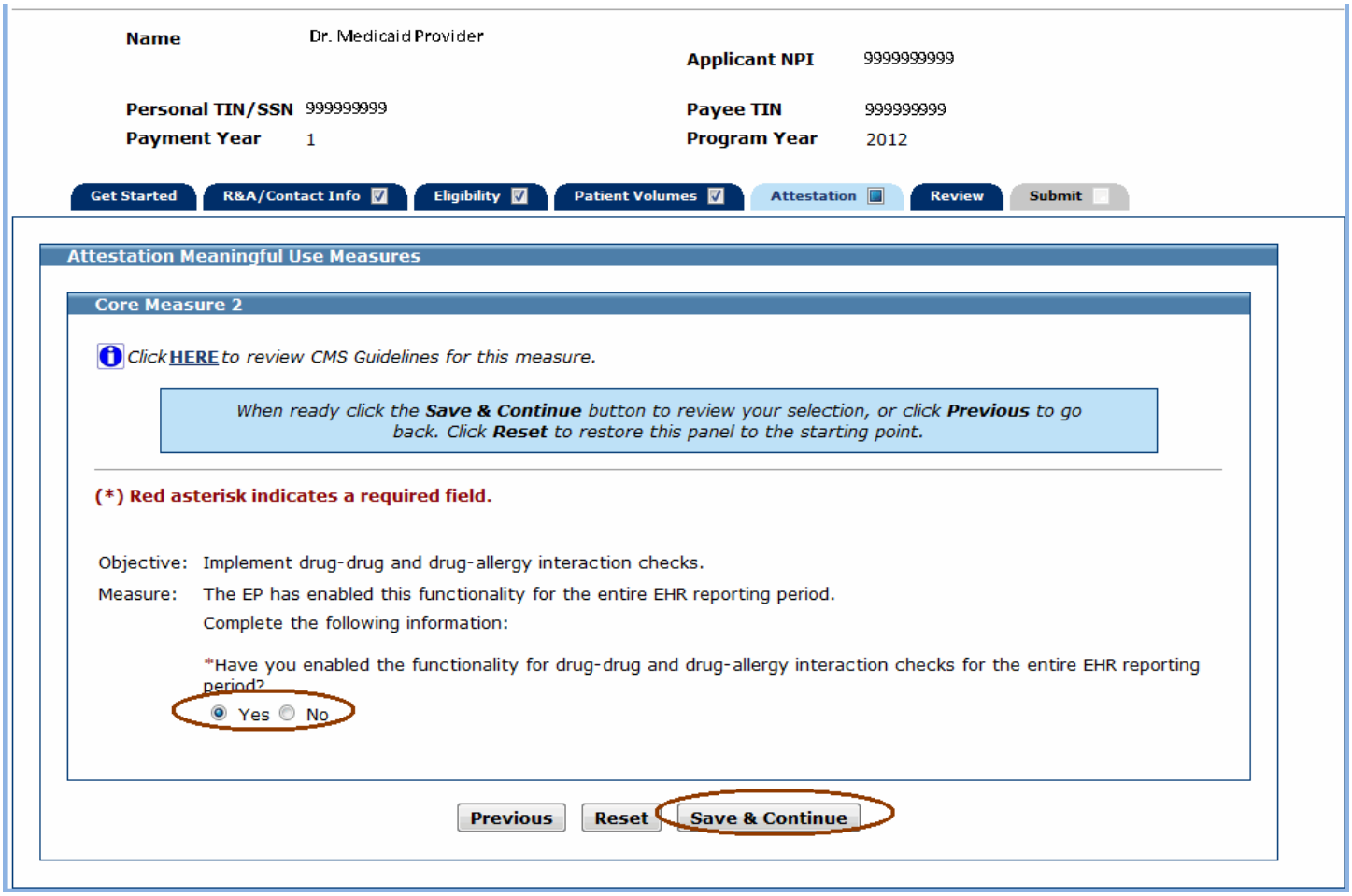
Core Measures 1 Original, 1 Optional, 9, 12, and 13


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 1
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Measure: More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
* PATIENT RECORDS : Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION- Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply please complete the following information:
Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator = Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
* Numerator : 65
* Denominator : 100
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Core Measures use this screen layout:

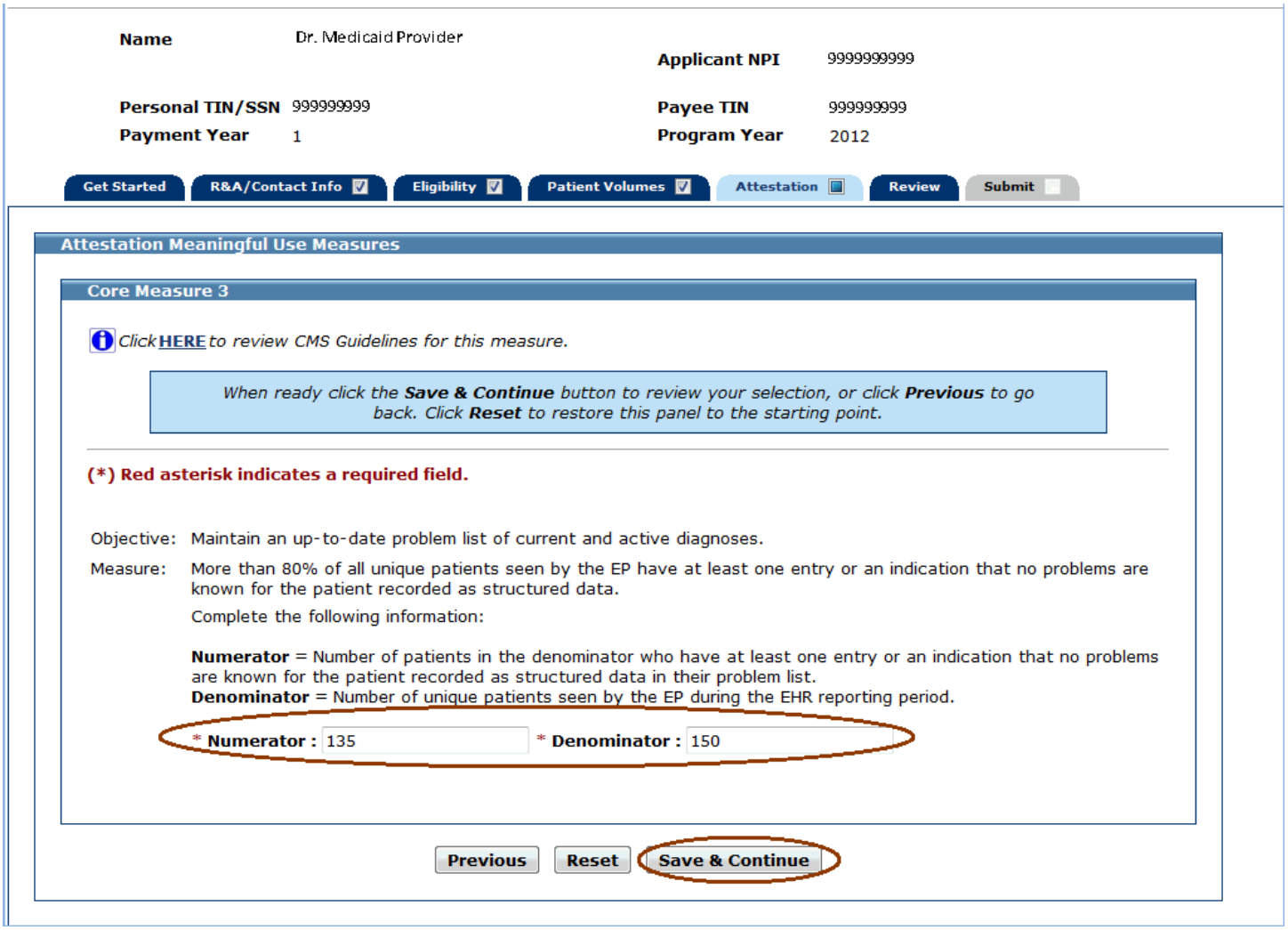
Core Measures 2, 11, 15



Screen 3

The following Meaningful Use Core Measures use this screen layout:

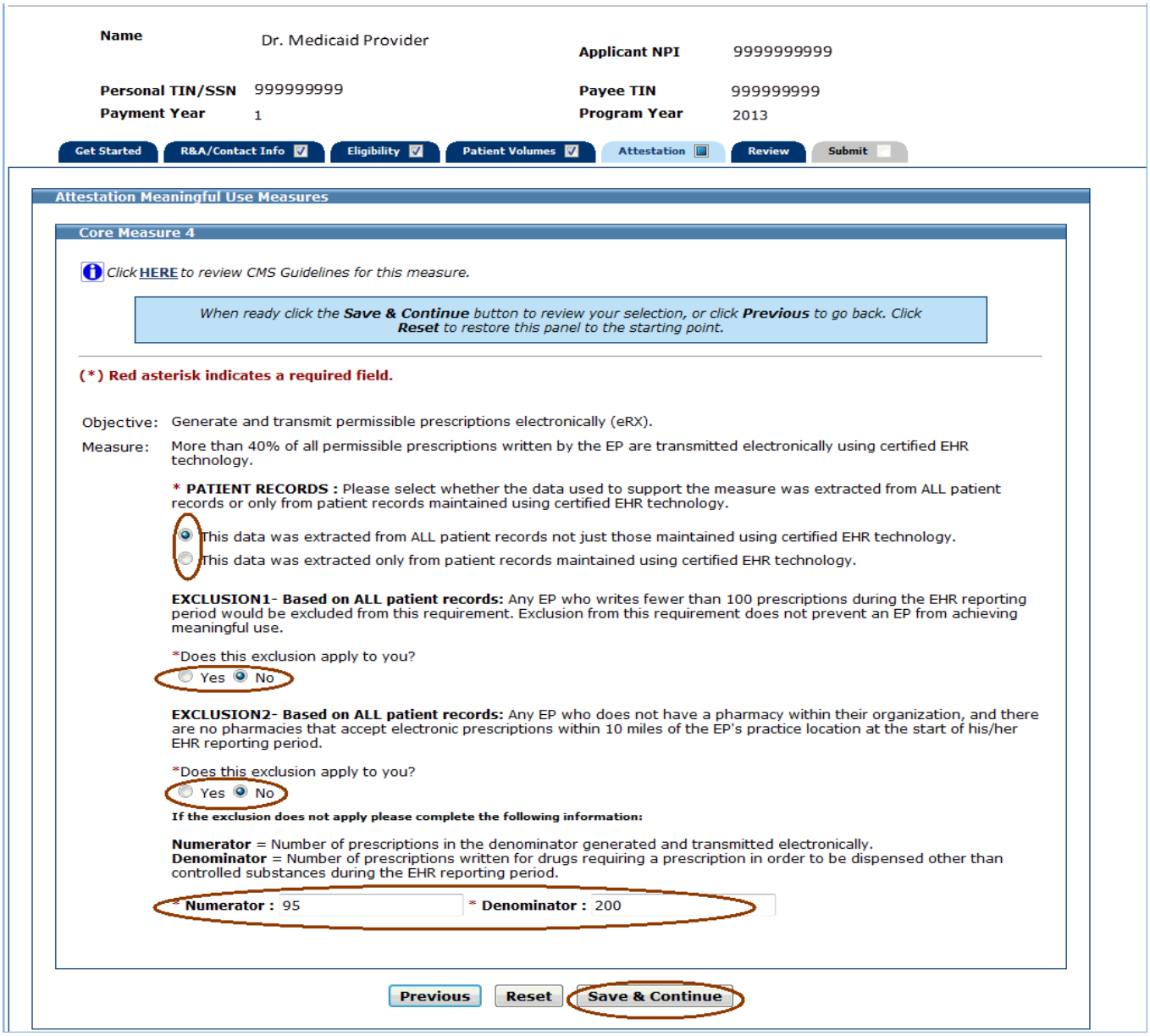
Core Measures 3, 5, 6, and 7


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 3
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Maintain an up-to-date problem list of current and active diagnoses.
Measure: More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Complete the following information:
Numerator = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.
* Numerator : 135
* Denominator : 150
Previous
Reset
Save & Continue

Screen 4

The following Meaningful Use Core Measures use this screen layout:

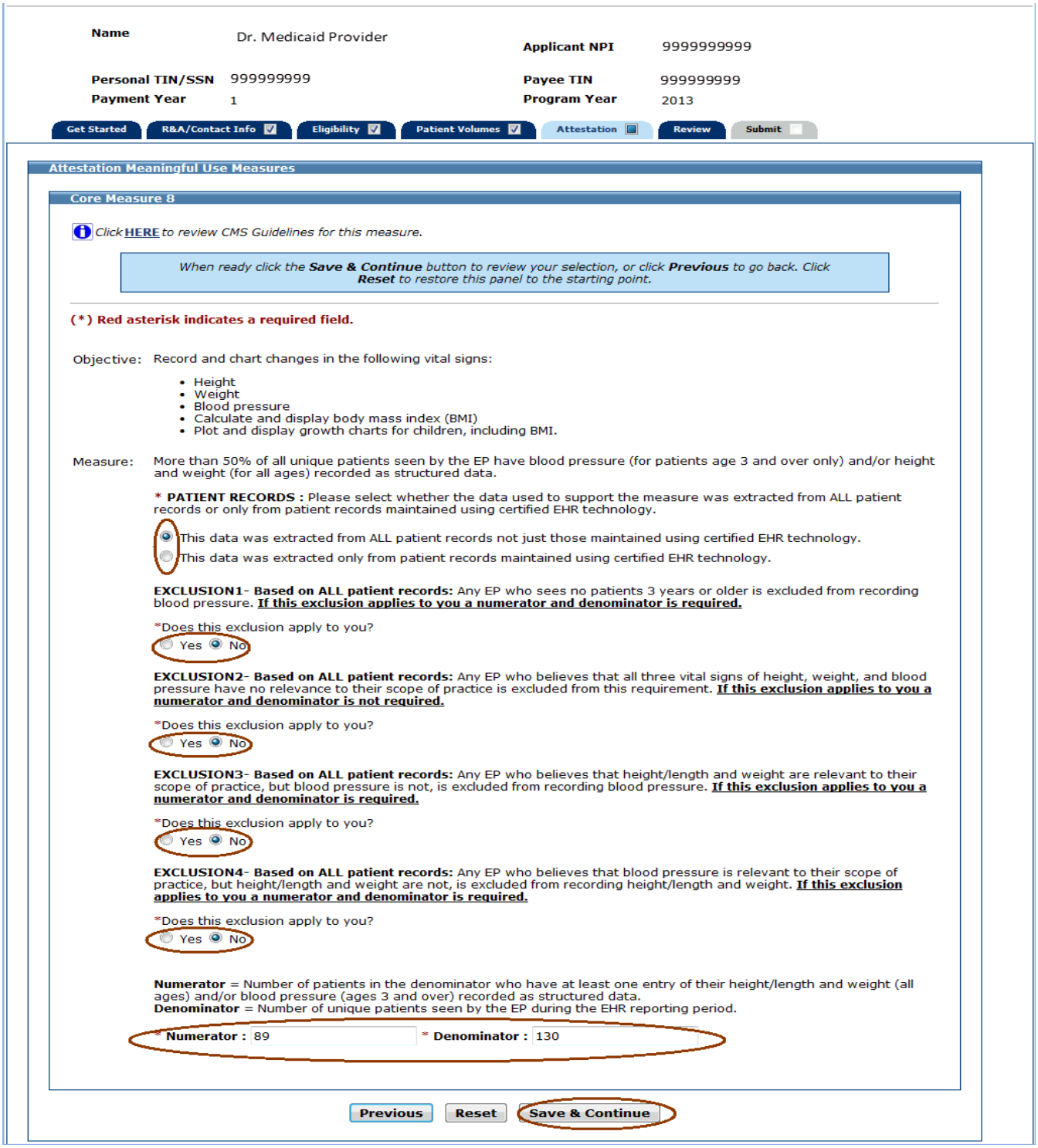
Core Measures 4 and 8 Original


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 4
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Generate and transmit permissible prescriptions electronically (eRX).
Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
* PATIENT RECORDS : Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION1- Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
EXCLUSION2- Based on ALL patient records: Any EP who does not have a pharmacy within their organization, and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
*Does this exclusion apply to you?
Yes No
If the exclusion does not apply please complete the following information:
Numerator = Number of prescriptions in the denominator generated and transmitted electronically.
Denominator = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
* Numerator : 95
* Denominator : 200
Previous
Reset
Save & Continue

Screen 5

The following Meaningful Use Core Measures use this screen layout:

Core Measure 8 Optional


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 8
Click HERE to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Record and chart changes in the following vital signs:
Height
Weight
Blood pressure
Calculate and display body mass index (BMI)
Plot and display growth charts for children, including BMI.
Measure: More than 50% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
* PATIENT RECORDS : Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION1- Based on ALL patient records: Any EP who sees no patients 3 years or older is excluded from recording blood pressure. If this exclusion applies to you a numerator and denominator is required.
*Does this exclusion apply to you?
Yes No
EXCLUSION2- Based on ALL patient records: Any EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from this requirement. If this exclusion applies to you a numerator and denominator is not required.
*Does this exclusion apply to you?
Yes No
EXCLUSION3- Based on ALL patient records: Any EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. If this exclusion applies to you a numerator and denominator is required.
*Does this exclusion apply to you?
Yes No
EXCLUSION4- Based on ALL patient records: Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight. If this exclusion applies to you a numerator and denominator is required.
*Does this exclusion apply to you?
Yes No
Numerator = Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.
* Numerator : 89
* Denominator : 130
Previous
Reset
Save & Continue

You may only select Yes to one exclusion.

If **Exclusion1** applies to you, answer the Patient Records question, select **Yes** to Exclusion1, select **No** to all other exclusions, and enter a numerator and denominator.

If **Exclusion2** applies to you, answer the Patient Records question, select **Yes** to Exclusion2, and **do not** enter a numerator and denominator.

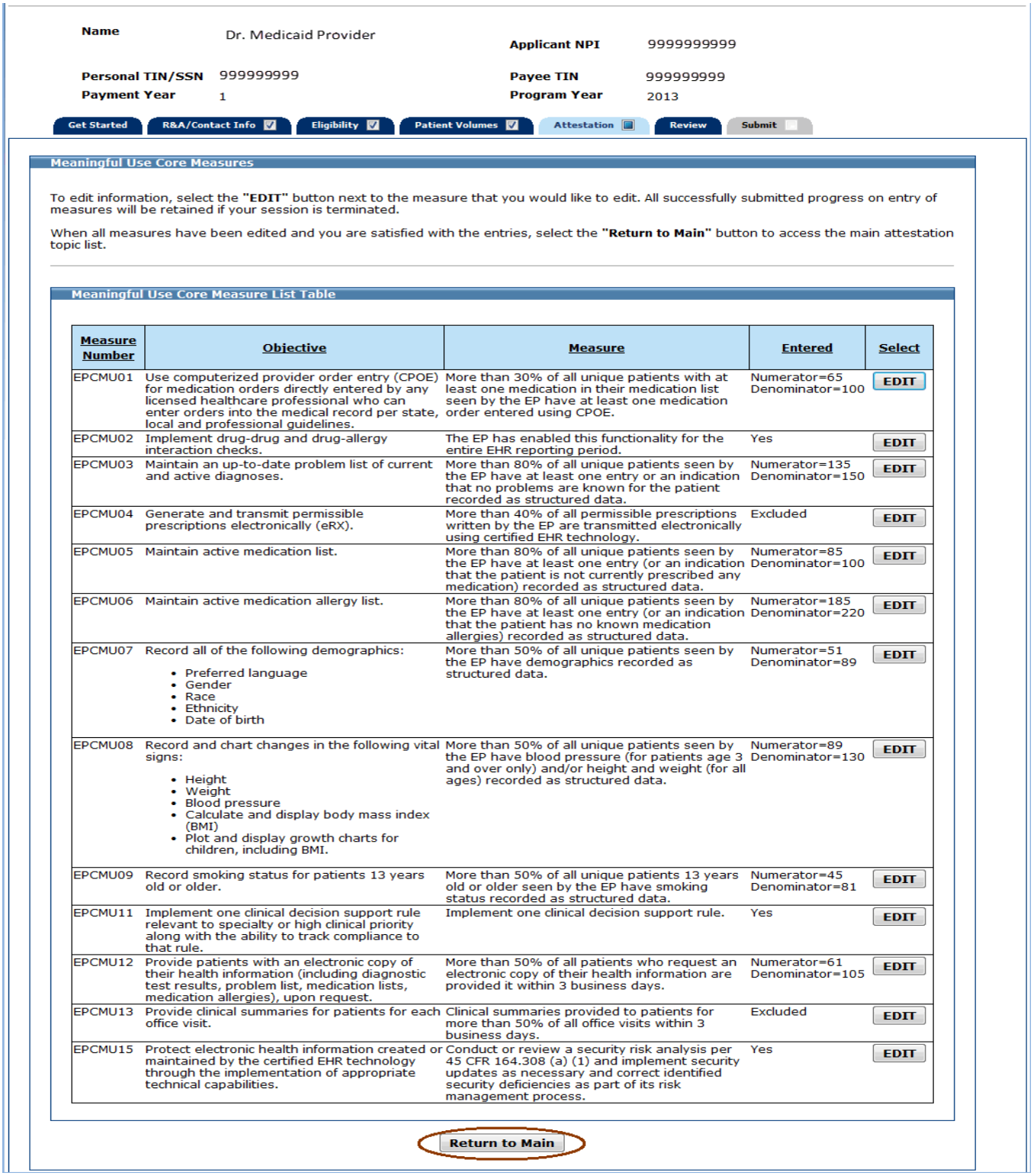
If **Exclusion3** applies to you, answer the Patient Records question, select **Yes** to Exclusion3, select **No** to all other exclusions, and enter a numerator and denominator.

If **Exclusion4** applies to you, answer the Patient Records question, select **Yes** to Exclusion4, select **No** to all other exclusions, and enter a numerator and denominator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

The screen on the following page shows an example where Exclusion2 applies; therefore the numerator and denominator are not entered.

Once you attested to all the measures for this topic, click **Return to Main** to return to the Measures Topic List.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2013

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Meaningful Use Core Measures

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All successfully submitted progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

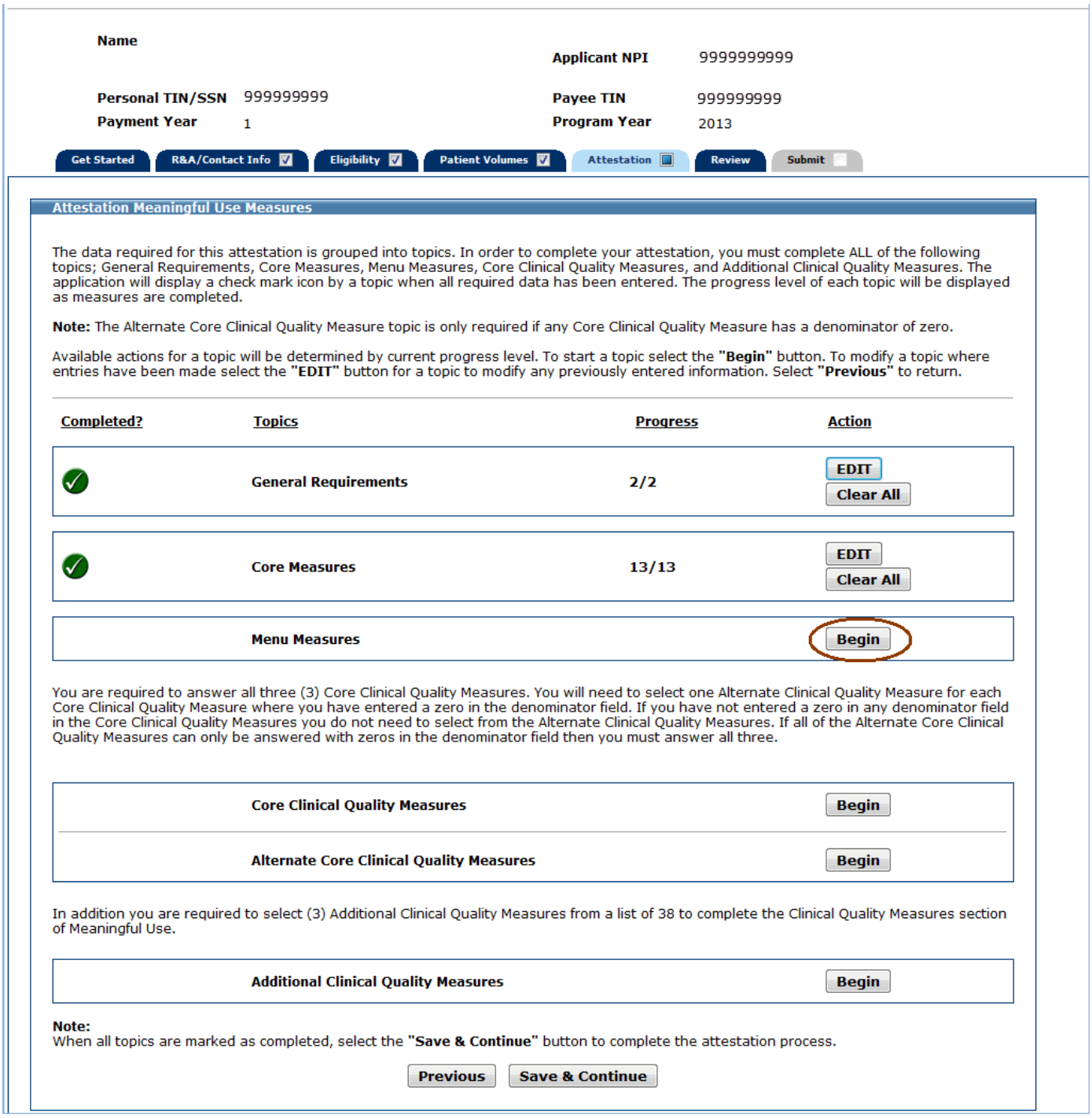
Meaningful Use Core Measure List Table

Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Numerator=65 Denominator=100	EDIT
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	Yes	EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator=135 Denominator=150	EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Excluded	EDIT
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator=85 Denominator=100	EDIT
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator=185 Denominator=220	EDIT
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	Numerator=51 Denominator=89	EDIT
EPCMU08	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children, including BMI.	More than 50% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.	Numerator=89 Denominator=130	EDIT
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Numerator=45 Denominator=81	EDIT
EPCMU11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.	Yes	EDIT
EPCMU12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.	Numerator=61 Denominator=105	EDIT
EPCMU13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Excluded	EDIT
EPCMU15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	EDIT

Return to Main

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Name
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 1
Program Year 2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
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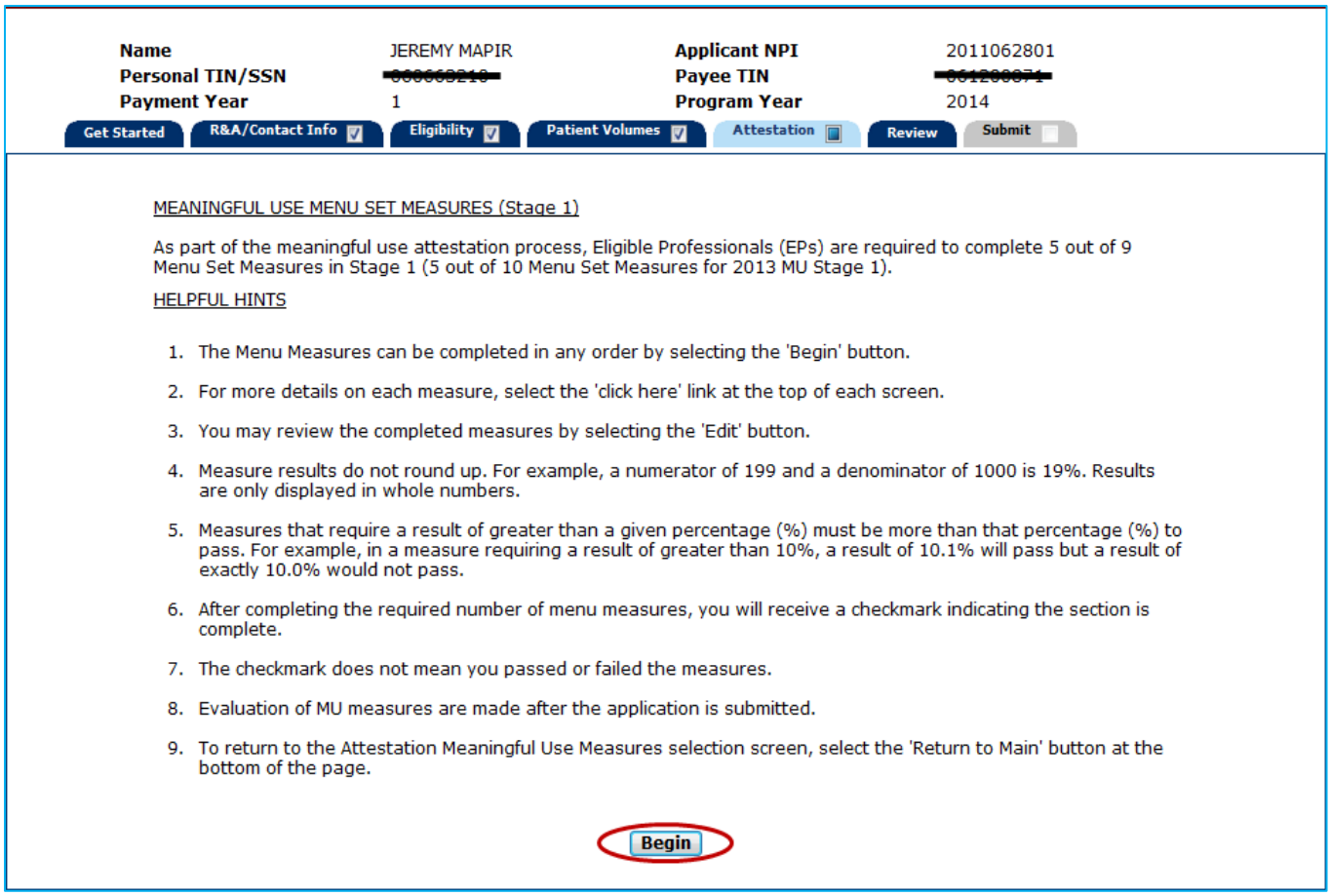
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed? Topics Progress Action
General Requirements 2/2 EDIT Clear All
Core Measures 13/13 EDIT Clear All
Menu Measures Begin
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures Begin
Alternate Core Clinical Quality Measures Begin
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous Save & Continue

Meaningful Use Menu Measures

This initial screen provides information about the Menu Measures.

Click **Begin** to continue to the Meaningful Use Menu Measures Selection screen.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
Payee TIN
Payment Year
1
Program Year
2014
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
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Submit
MEANINGFUL USE MENU SET MEASURES (Stage 1)
As part of the meaningful use attestation process, Eligible Professionals (EPs) are required to complete 5 out of 9 Menu Set Measures in Stage 1 (5 out of 10 Menu Set Measures for 2013 MU Stage 1).
HELPFUL HINTS
1. The Menu Measures can be completed in any order by selecting the 'Begin' button.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. Measure results do not round up. For example, a numerator of 199 and a denominator of 1000 is 19%. Results are only displayed in whole numbers.
5. Measures that require a result of greater than a given percentage (%) must be more than that percentage (%) to pass. For example, in a measure requiring a result of greater than 10%, a result of 10.1% will pass but a result of exactly 10.0% would not pass.
6. After completing the required number of menu measures, you will receive a checkmark indicating the section is complete.
7. The checkmark does not mean you passed or failed the measures.
8. Evaluation of MU measures are made after the application is submitted.
9. To return to the Attestation Meaningful Use Measures selection screen, select the 'Return to Main' button at the bottom of the page.
Begin

From the Meaningful Use Menu Measures Selection screen displayed on the following page, choose five Meaningful Use Menu Measures to attest to. One measure must be from the public health list (first two measures listed on the top half of the screen). The remainder of the measures can be any combination from the remaining public health list measures or from the additional Meaningful Use Menu Measures listed. In the example shown on the following page, one public health measure and four measures from the additional Meaningful Use Measures listed are selected.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.

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Attestation Meaningful Use Measures

Instructions:

Eligible Professionals must report on a minimum of five (5) Meaningful Use Menu Measures. EPMMU09 and EPMMU10 are the Public Health measures. Eligible Professionals are required to attest to at least one (1) Public Health measure and four (4) other Menu measures, or attest to two (2) Public Health measures and three (3) other menu measures. If an Eligible Professional can be excluded from both Public Health measures, the Eligible Professional must claim an exclusion from only one (1) Public Health measure and report on four (4) additional menu measures. Please refer to the tab introduction (splash page) for state specific information.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

*When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Measure Number	Objective	Public Heath Measure	Select
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	☑
EPMMU10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).	☐

You must submit additional menu measure objectives until a minimum of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected.

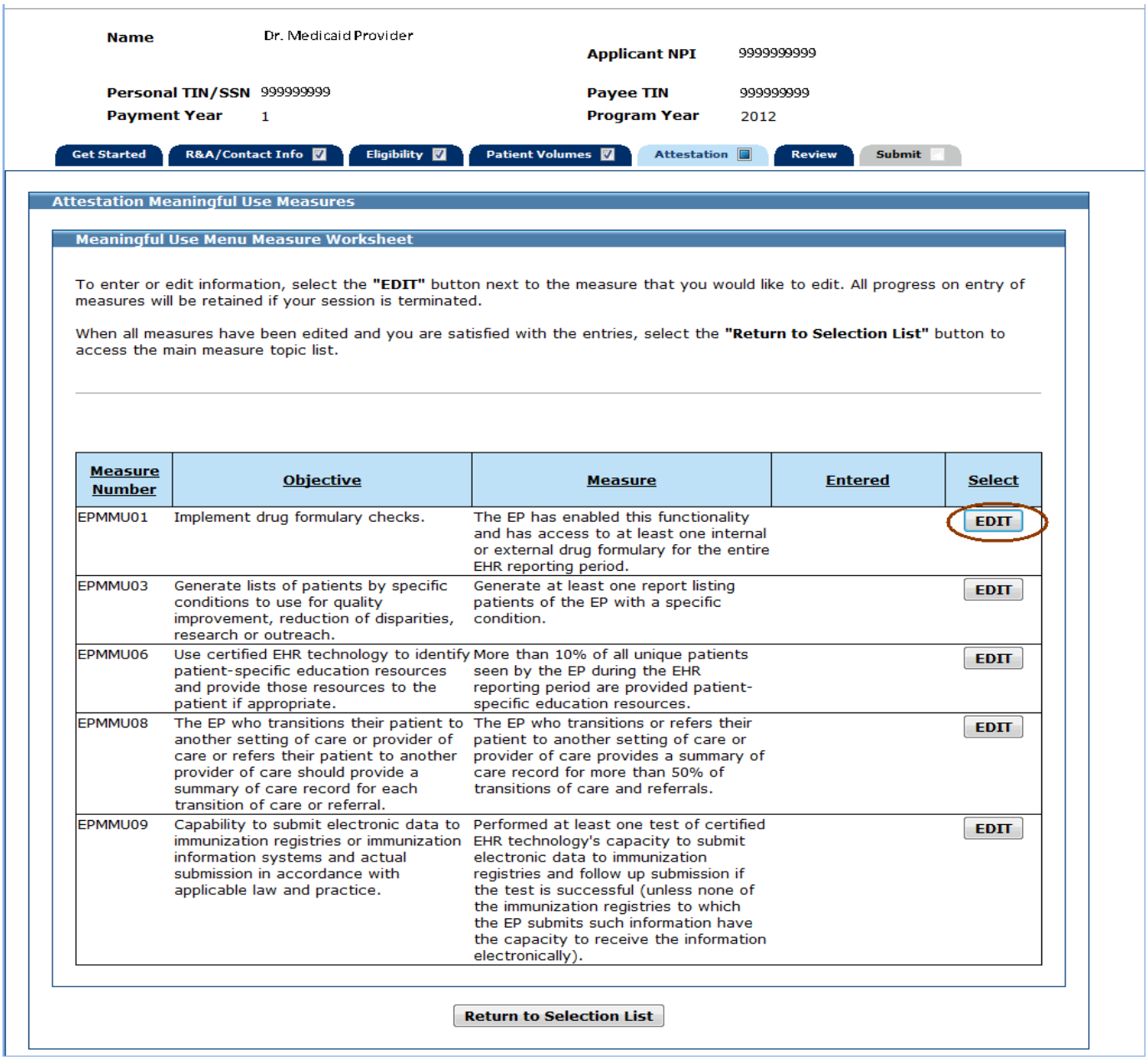
Measure Number	Objective	Measure	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
EPMMU02	Incorporate clinic lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☐
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	☑
EPMMU04	Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	☐
EPMMU05	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	☐
EPMMU06	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.	☑
EPMMU07	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	☐
EPMMU08	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☑

Return to Main | Reset | Save & Continue

The five measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the five measures selected on the previous screen example.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return to Selection List** to return to the Meaningful Use Menu Measures Selection screen.



Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2012

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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.		EDIT
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.		EDIT
EPMMU06	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.		EDIT
EPMMU08	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.		EDIT
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).		EDIT

Return to Selection List

The following is a list of the Meaningful Use Menu Measures that you may attest to.

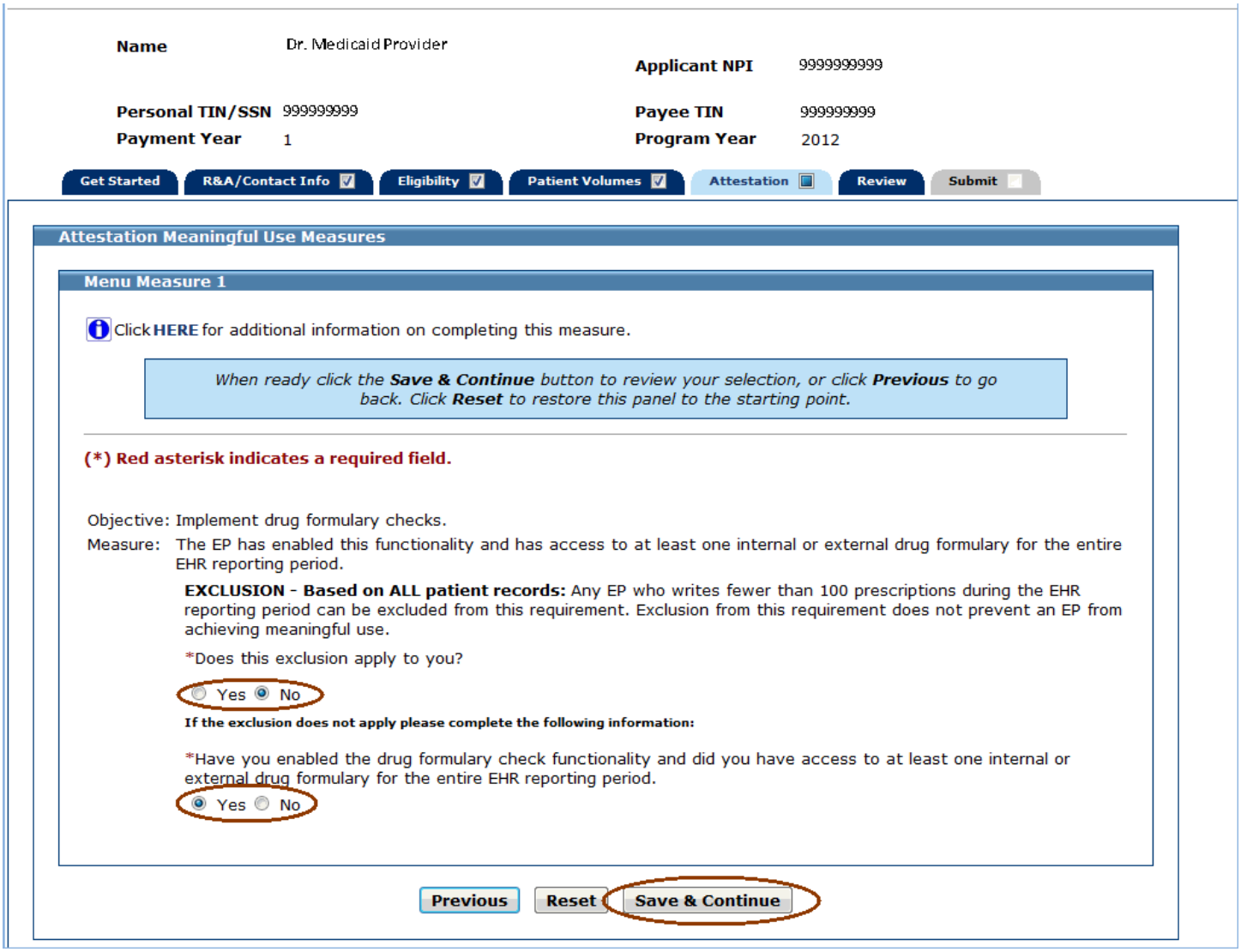
Click on the Screen Example to see an example of the screen layout.

Meaningful Use Menu Measure	Screen Example
Menu Measure 1	Screen 1
Menu Measure 2	Screen 2
Menu Measure 3	Screen 3
Menu Measure 4	Screen 4
Menu Measure 5	Screen 4
Menu Measure 6	Screen 5
Menu Measure 7	Screen 4
Menu Measure 8	Screen 4
Menu Measure 9	Screen 6
Menu Measure 10	Screen 6

Screen 1

The following Meaningful Use Menu Measures use this screen layout:

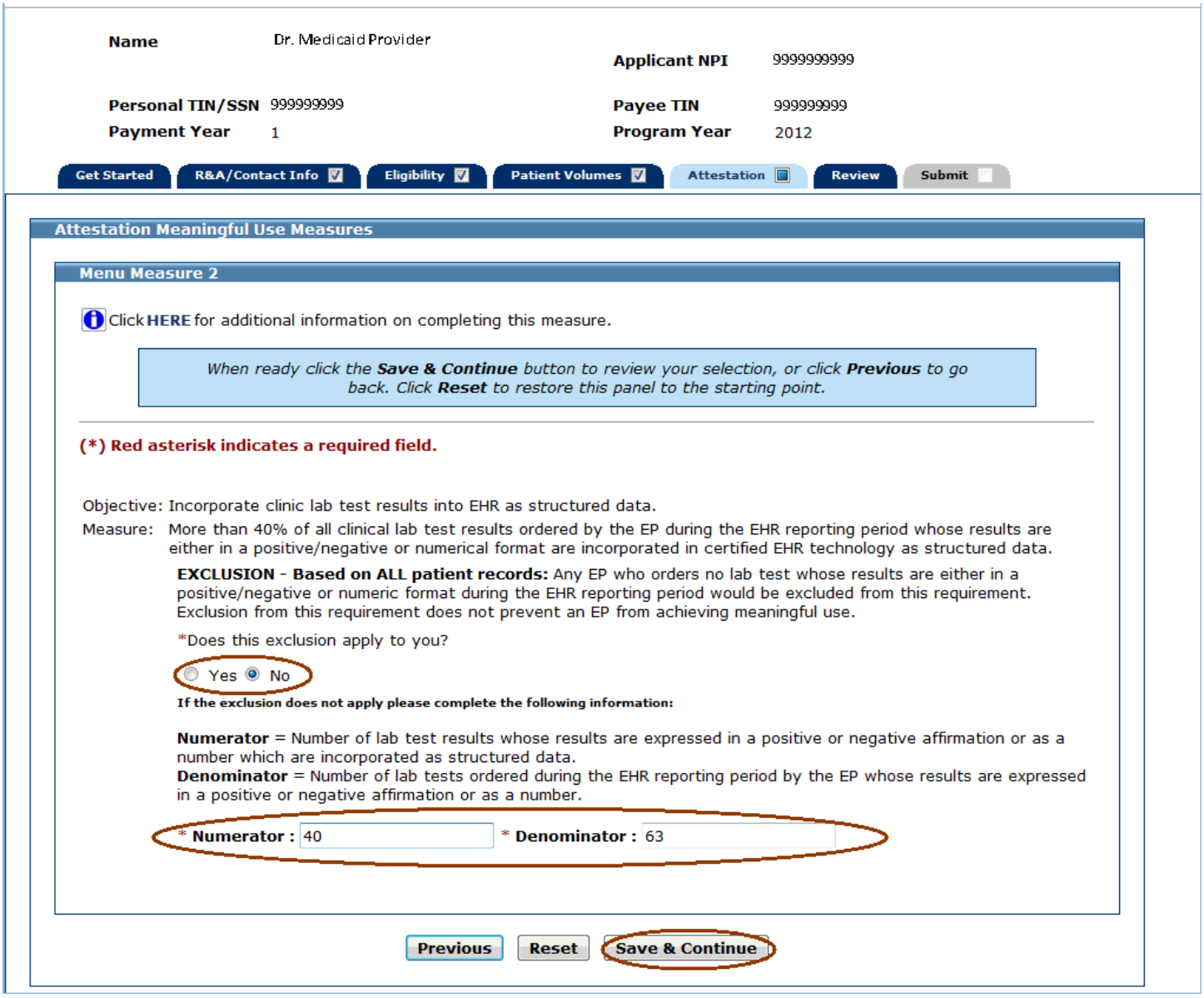
Menu Measure 1


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 1
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Implement drug formulary checks.
Measure: The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
EXCLUSION - Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
If the exclusion does not apply please complete the following information:
*Have you enabled the drug formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period.
Yes No
Previous
Reset
Save & Continue

Screen 2

The following Meaningful Use Menu Measures use this screen layout:

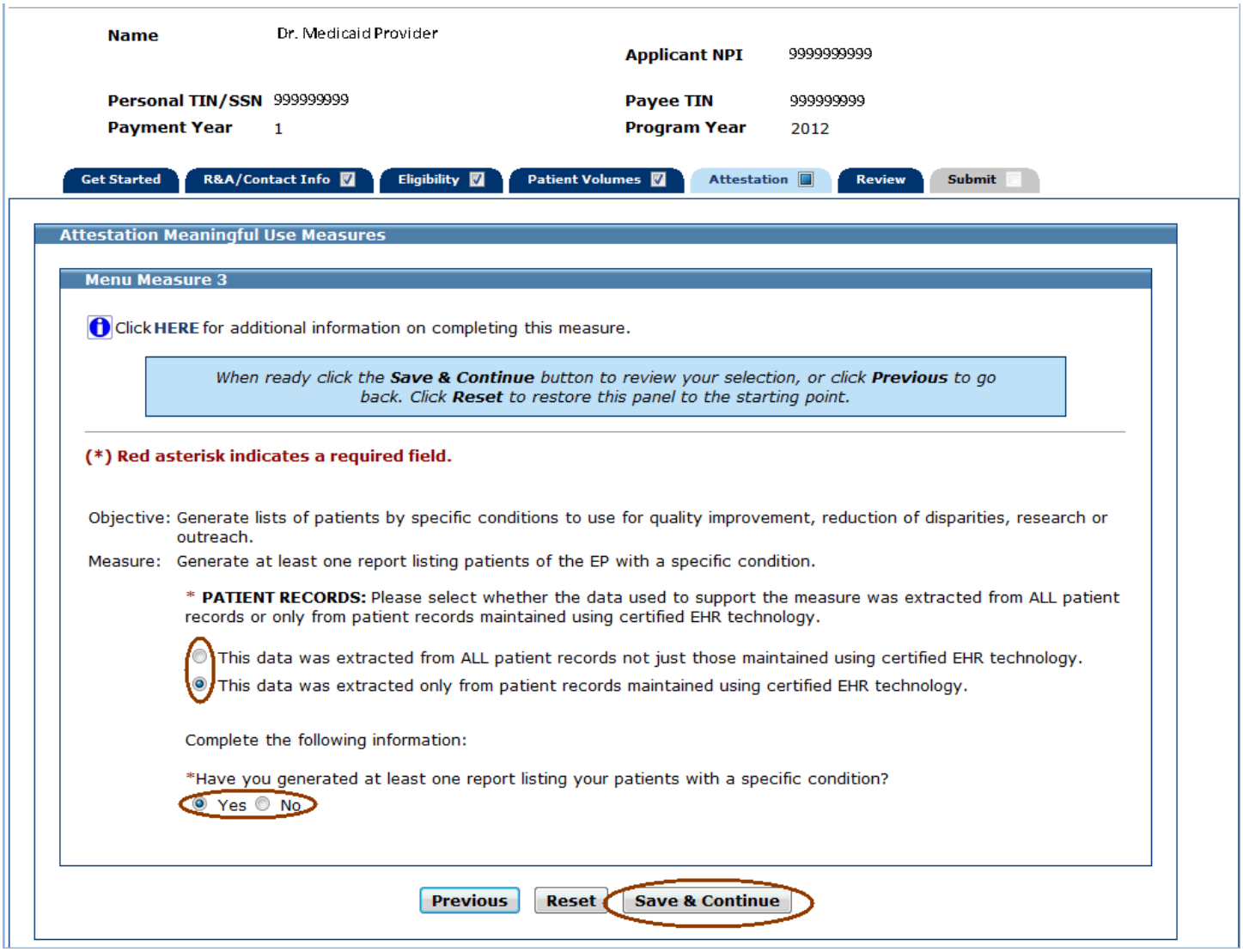
Menu Measure 2


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 2
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Incorporate clinic lab test results into EHR as structured data.
Measure: More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
EXCLUSION - Based on ALL patient records: Any EP who orders no lab test whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply please complete the following information:
Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Denominator = Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
* Numerator : 40
* Denominator : 63
Previous
Reset
Save & Continue

Screen 3

The following Meaningful Use Menu Measures use this screen layout:

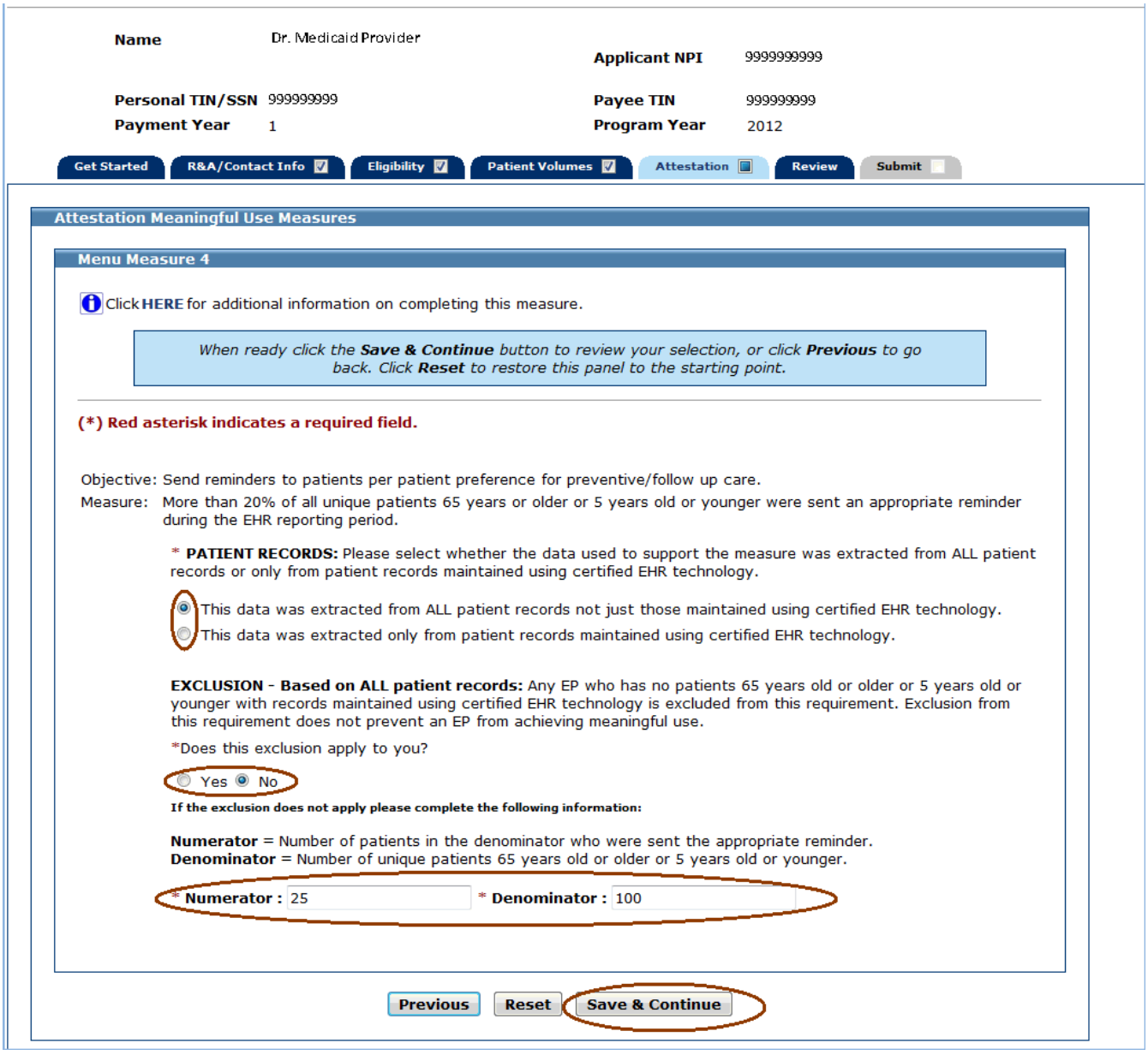
Menu Measure 3


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 3
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.
Measure: Generate at least one report listing patients of the EP with a specific condition.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
Complete the following information:
*Have you generated at least one report listing your patients with a specific condition?
Yes
No
Previous
Reset
Save & Continue

Screen 4

The following Meaningful Use Menu Measures use this screen layout:

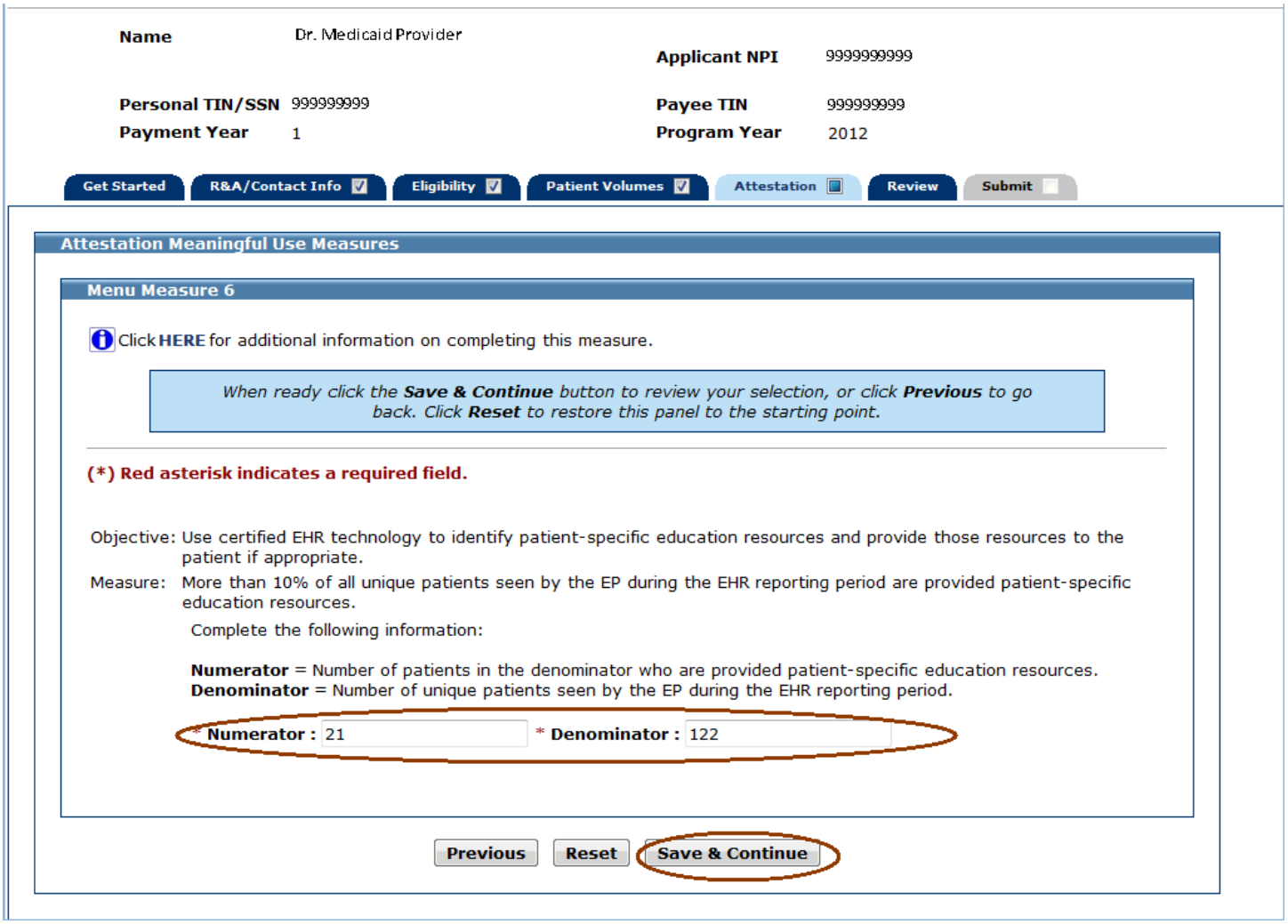
Menu Measure 4, 5, 7, and 8


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 4
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Send reminders to patients per patient preference for preventive/follow up care.
Measure: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
This data was extracted from ALL patient records not just those maintained using certified EHR technology.
This data was extracted only from patient records maintained using certified EHR technology.
EXCLUSION - Based on ALL patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes
No
If the exclusion does not apply please complete the following information:
Numerator = Number of patients in the denominator who were sent the appropriate reminder.
Denominator = Number of unique patients 65 years old or older or 5 years old or younger.
* Numerator : 25
* Denominator : 100
Previous
Reset
Save & Continue

Screen 5

The following Meaningful Use Menu Measures use this screen layout:

Menu Measure 6


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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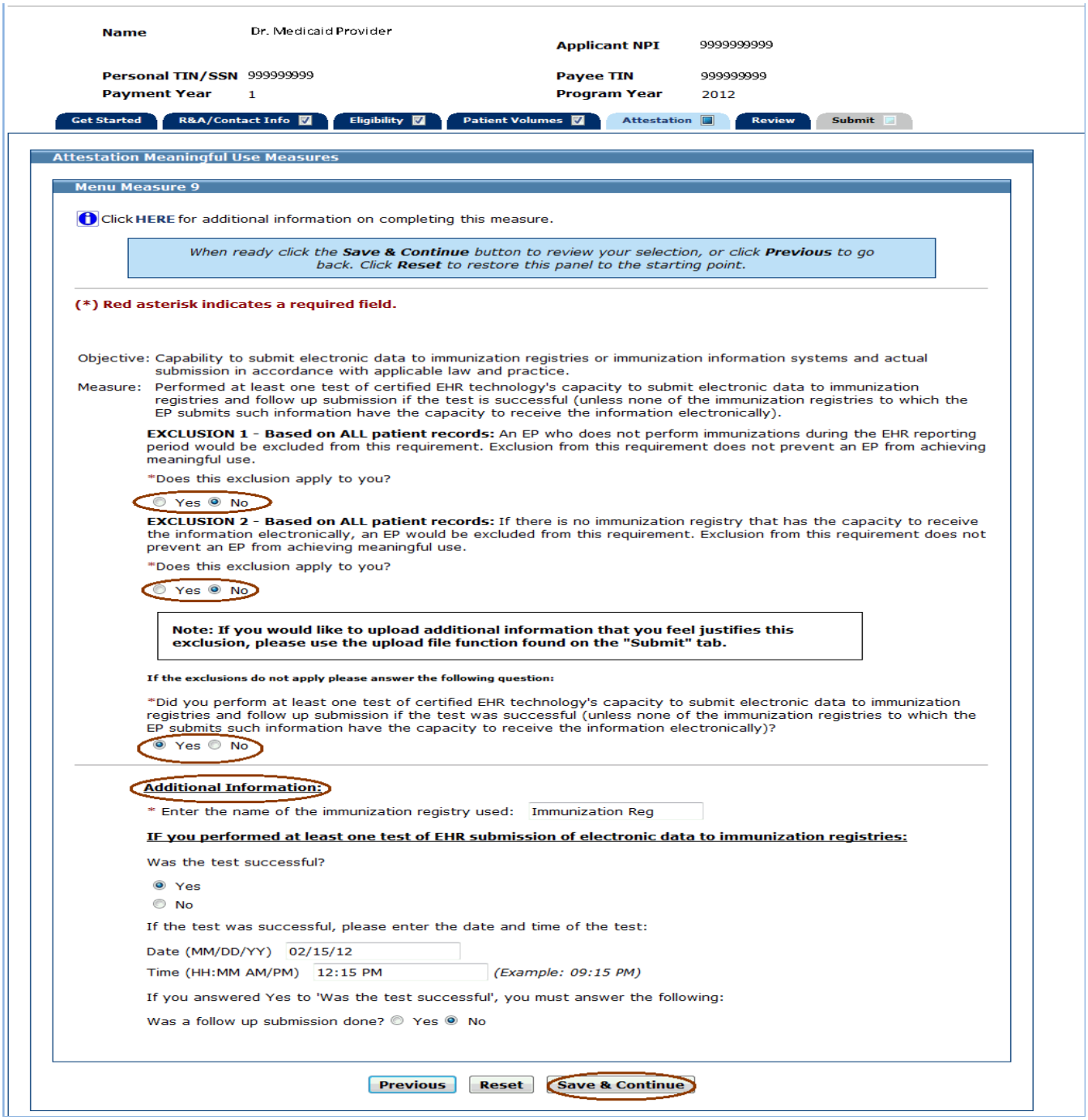
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 6
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure: More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.
Complete the following information:
Numerator = Number of patients in the denominator who are provided patient-specific education resources.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.
* Numerator : 21
* Denominator : 122
Previous
Reset
Save & Continue

Screen 6

The following Meaningful Use Menu Measures use this screen layout:

Menu Measure 9 and 10


Name
Dr. Medicaid Provider
Applicant NPI
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Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
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Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 9
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).
EXCLUSION 1 - Based on ALL patient records: An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
EXCLUSION 2 - Based on ALL patient records: If there is no immunization registry that has the capacity to receive the information electronically, an EP would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
Note: If you would like to upload additional information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab.
If the exclusions do not apply please answer the following question:
*Did you perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)?
Yes No
Additional Information:
* Enter the name of the immunization registry used: Immunization Reg
IF you performed at least one test of EHR submission of electronic data to immunization registries:
Was the test successful?
Yes
No
If the test was successful, please enter the date and time of the test:
Date (MM/DD/YY) 02/15/12
Time (HH:MM AM/PM) 12:15 PM (Example: 09:15 PM)
If you answered Yes to 'Was the test successful', you must answer the following:
Was a follow up submission done? Yes No
Previous
Reset
Save & Continue

If Exclusion 1 and/or Exclusion 2 apply to you select **Yes** and do not answer the EHR technology question.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Menu Measure Selection screen.

Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999

Payee TIN 999999999

Payment Year 1

Program Year 2012

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Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

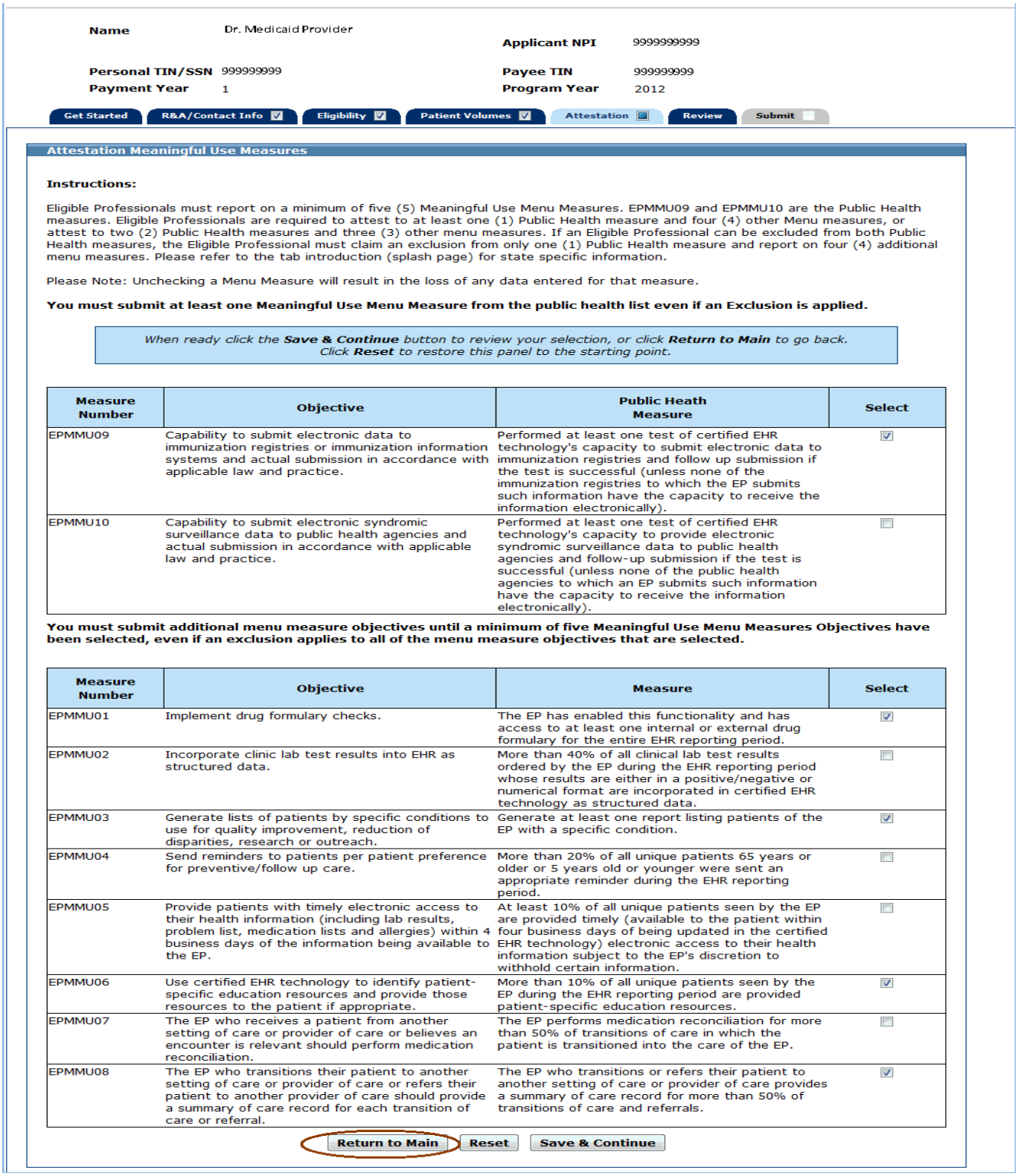
To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main measure topic list.

Measure Number	Objective	Measure	Entered	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	EDIT
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes	EDIT
EPMMU06	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.	Numerator= 21 Denominator= 122	EDIT
EPMMU08	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	Numerator= 93 Denominator= 153	EDIT
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	No No	EDIT

Return to Selection List

Click **Return to Main** to return to the Measure Topic List.



Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 1
Program Year 2012

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Attestation Meaningful Use Measures

Instructions:

Eligible Professionals must report on a minimum of five (5) Meaningful Use Menu Measures. EPMMU09 and EPMMU10 are the Public Health measures. Eligible Professionals are required to attest to at least one (1) Public Health measure and four (4) other Menu measures, or attest to two (2) Public Health measures and three (3) other menu measures. If an Eligible Professional can be excluded from both Public Health measures, the Eligible Professional must claim an exclusion from only one (1) Public Health measure and report on four (4) additional menu measures. Please refer to the tab introduction (splash page) for state specific information.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

*When ready click the **Save & Continue** button to review your selection, or click **Return to Main** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Measure Number	Objective	Public Heath Measure	Select
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	☑
EPMMU10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).	☐

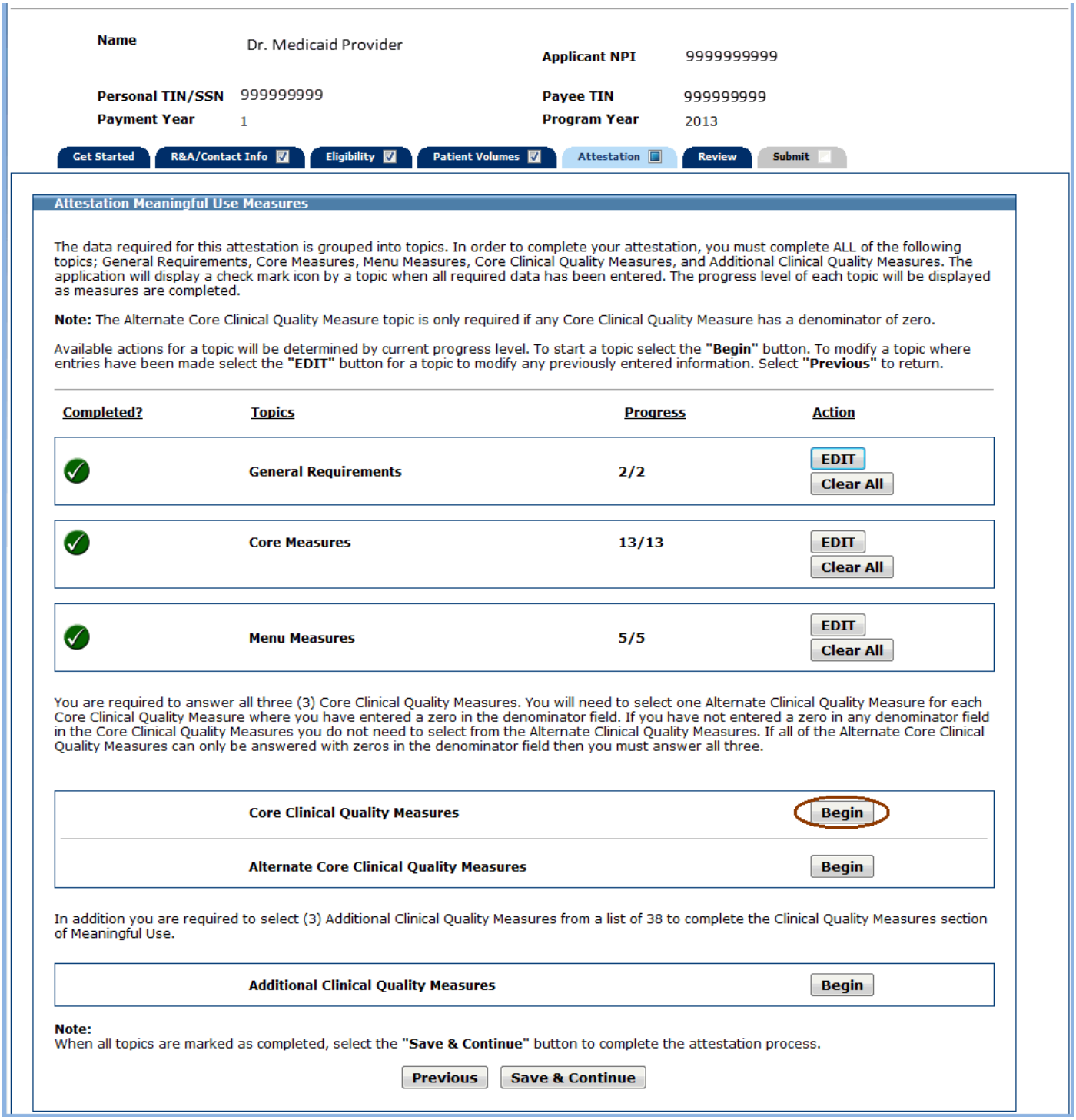
You must submit additional menu measure objectives until a minimum of five Meaningful Use Menu Measures Objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected.

Measure Number	Objective	Measure	Select
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
EPMMU02	Incorporate clinic lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☐
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	☑
EPMMU04	Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	☐
EPMMU05	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	☐
EPMMU06	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.	☑
EPMMU07	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	☐
EPMMU08	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☑

Return to Main | Reset | Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
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Patient Volumes
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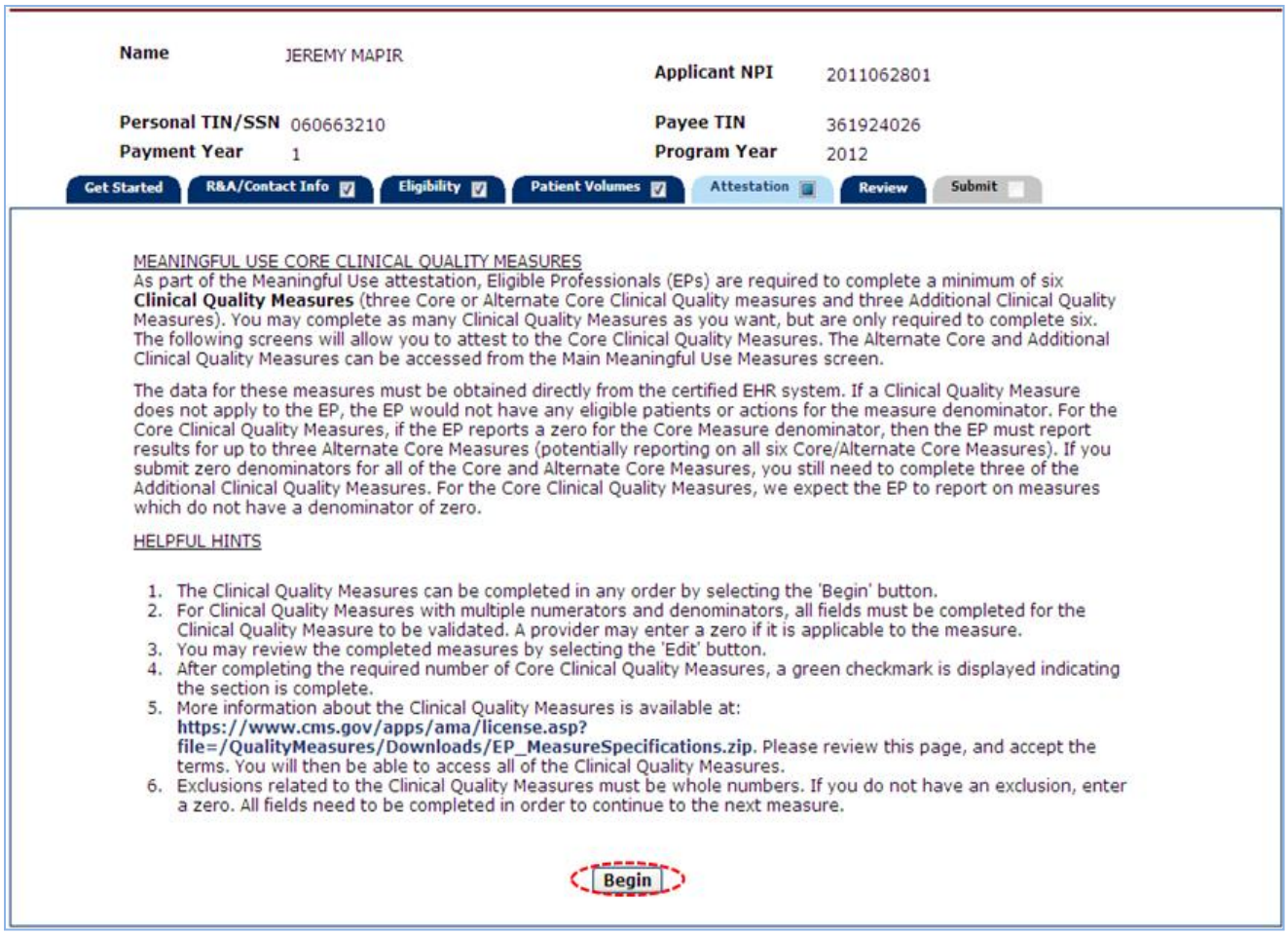
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
13/13
EDIT
Clear All
Menu Measures
5/5
EDIT
Clear All
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures
Begin
Alternate Core Clinical Quality Measures
Begin
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Core Clinical Quality Measures

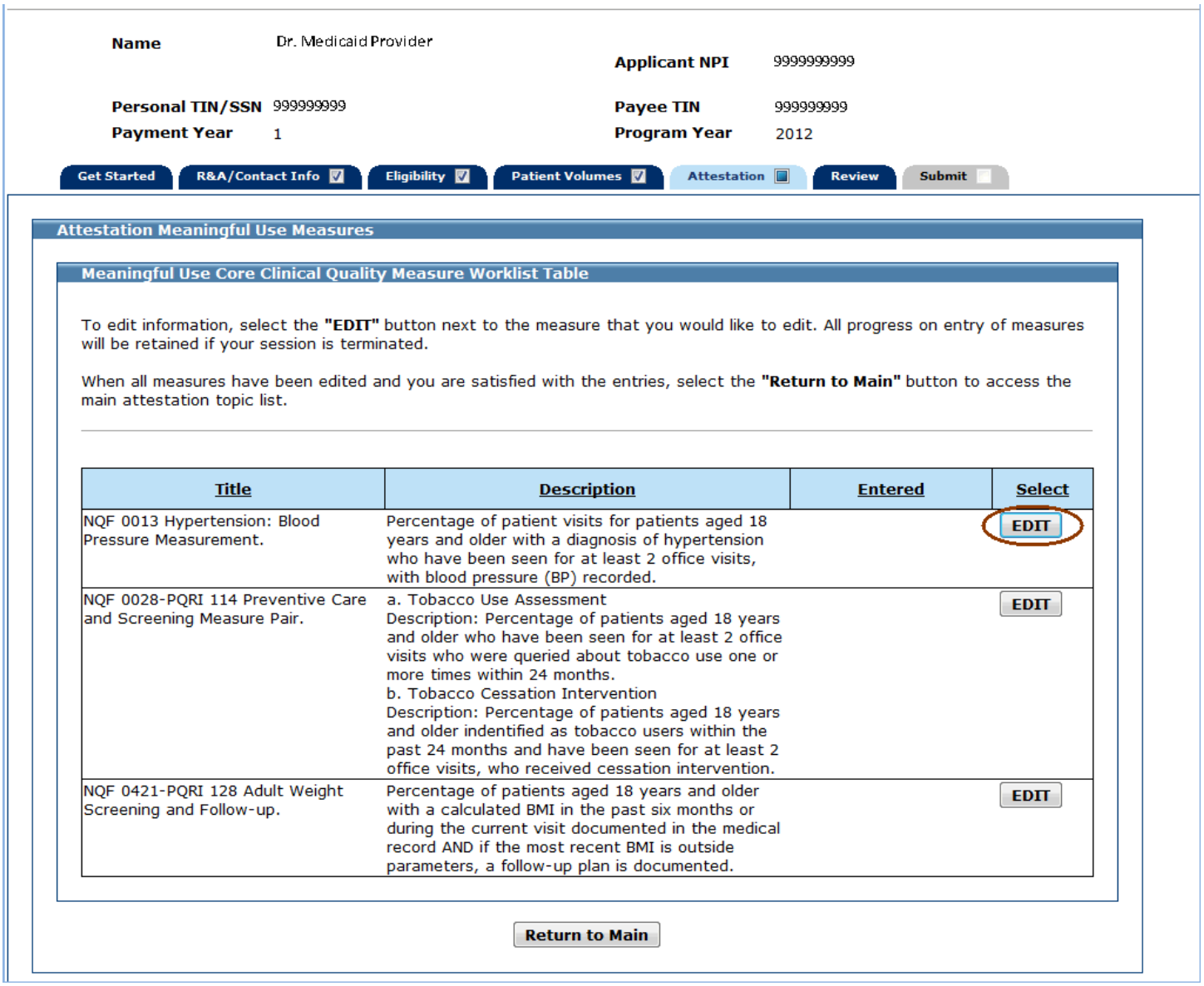
This initial screen provides information about the Meaningful Use Core Clinical Quality Measures. Click **Begin** to continue to the Meaningful Use Core Clinical Quality Measure Worklist Table.


Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN 060663210
Payee TIN 361924026
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE CORE CLINICAL QUALITY MEASURES
As part of the Meaningful Use attestation, Eligible Professionals (EPs) are required to complete a minimum of six Clinical Quality Measures (three Core or Alternate Core Clinical Quality measures and three Additional Clinical Quality Measures). You may complete as many Clinical Quality Measures as you want, but are only required to complete six. The following screens will allow you to attest to the Core Clinical Quality Measures. The Alternate Core and Additional Clinical Quality Measures can be accessed from the Main Meaningful Use Measures screen.
The data for these measures must be obtained directly from the certified EHR system. If a Clinical Quality Measure does not apply to the EP, the EP would not have any eligible patients or actions for the measure denominator. For the Core Clinical Quality Measures, if the EP reports a zero for the Core Measure denominator, then the EP must report results for up to three Alternate Core Measures (potentially reporting on all six Core/Alternate Core Measures). If you submit zero denominators for all of the Core and Alternate Core Measures, you still need to complete three of the Additional Clinical Quality Measures. For the Core Clinical Quality Measures, we expect the EP to report on measures which do not have a denominator of zero.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. For Clinical Quality Measures with multiple numerators and denominators, all fields must be completed for the Clinical Quality Measure to be validated. A provider may enter a zero if it is applicable to the measure.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing the required number of Core Clinical Quality Measures, a green checkmark is displayed indicating the section is complete.
5. More information about the Clinical Quality Measures is available at: https://www.cms.gov/apps/ama/license.asp?file=/QualityMeasures/Downloads/EP_MeasureSpecifications.zip. Please review this page, and accept the terms. You will then be able to access all of the Clinical Quality Measures.
6. Exclusions related to the Clinical Quality Measures must be whole numbers. If you do not have an exclusion, enter a zero. All fields need to be completed in order to continue to the next measure.
Begin

The screen on the following page displays the Meaningful Use Core Clinical Quality Measure Worklist Table. You must complete all measures.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for the measure or click **Return to Main** to return to the Measures Topic List.



Name Dr. Medicaid Provider

Applicant NPI 9999999999

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Payment Year 1 **Program Year** 2012

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Attestation Meaningful Use Measures

Meaningful Use Core Clinical Quality Measure Worklist Table

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Main"** button to access the main attestation topic list.

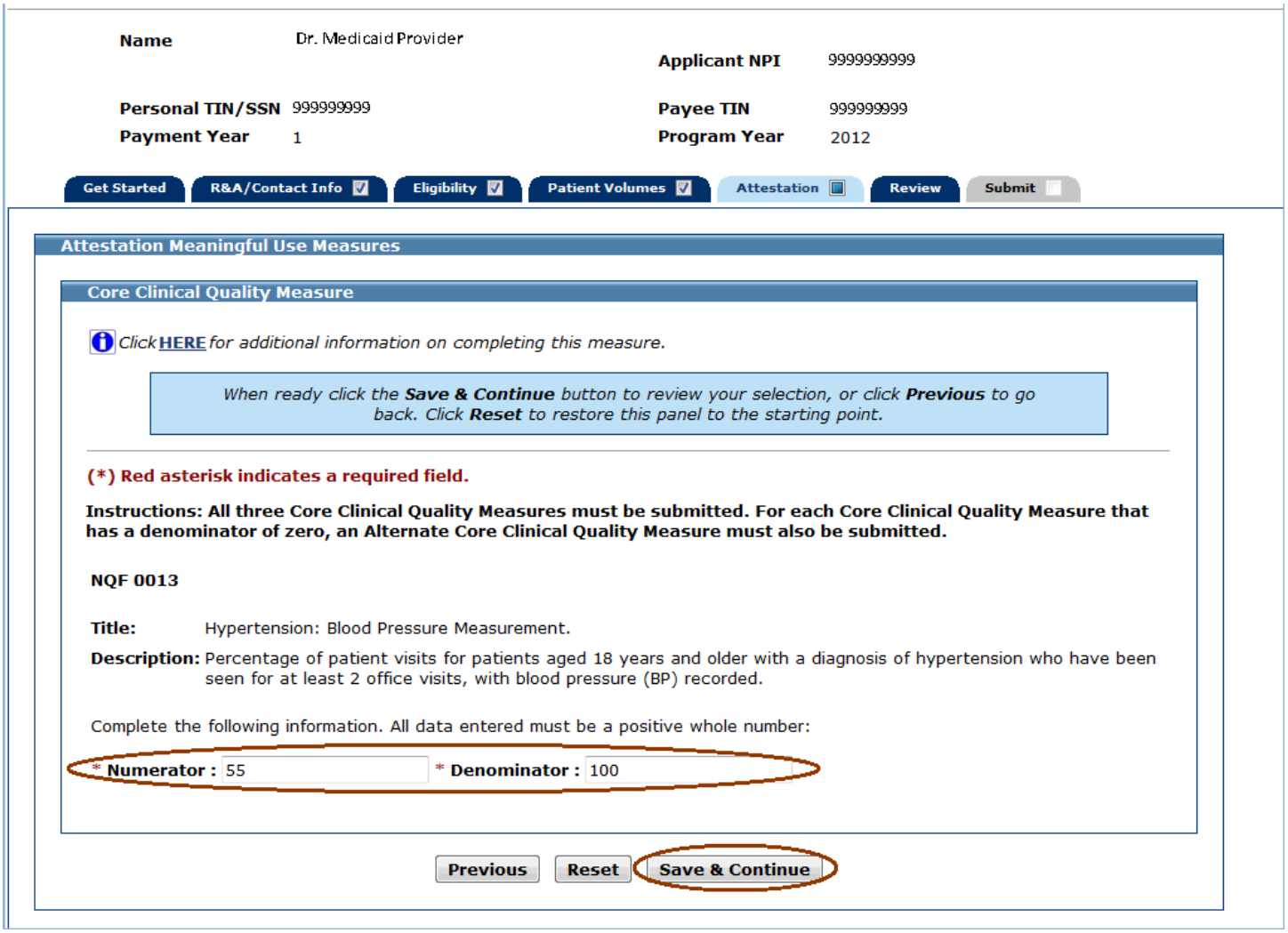
Title	Description	Entered	Select
NQF 0013 Hypertension: Blood Pressure Measurement.	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.		EDIT
NQF 0028-PQRI 114 Preventive Care and Screening Measure Pair.	a. Tobacco Use Assessment Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. b. Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older indentified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.		EDIT
NQF 0421-PQRI 128 Adult Weight Screening and Follow-up.	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.		EDIT

Return to Main

Core Clinical Quality Measure NQF 0013

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
Dr. Medicaid Provider
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Payee TIN
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Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
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Attestation
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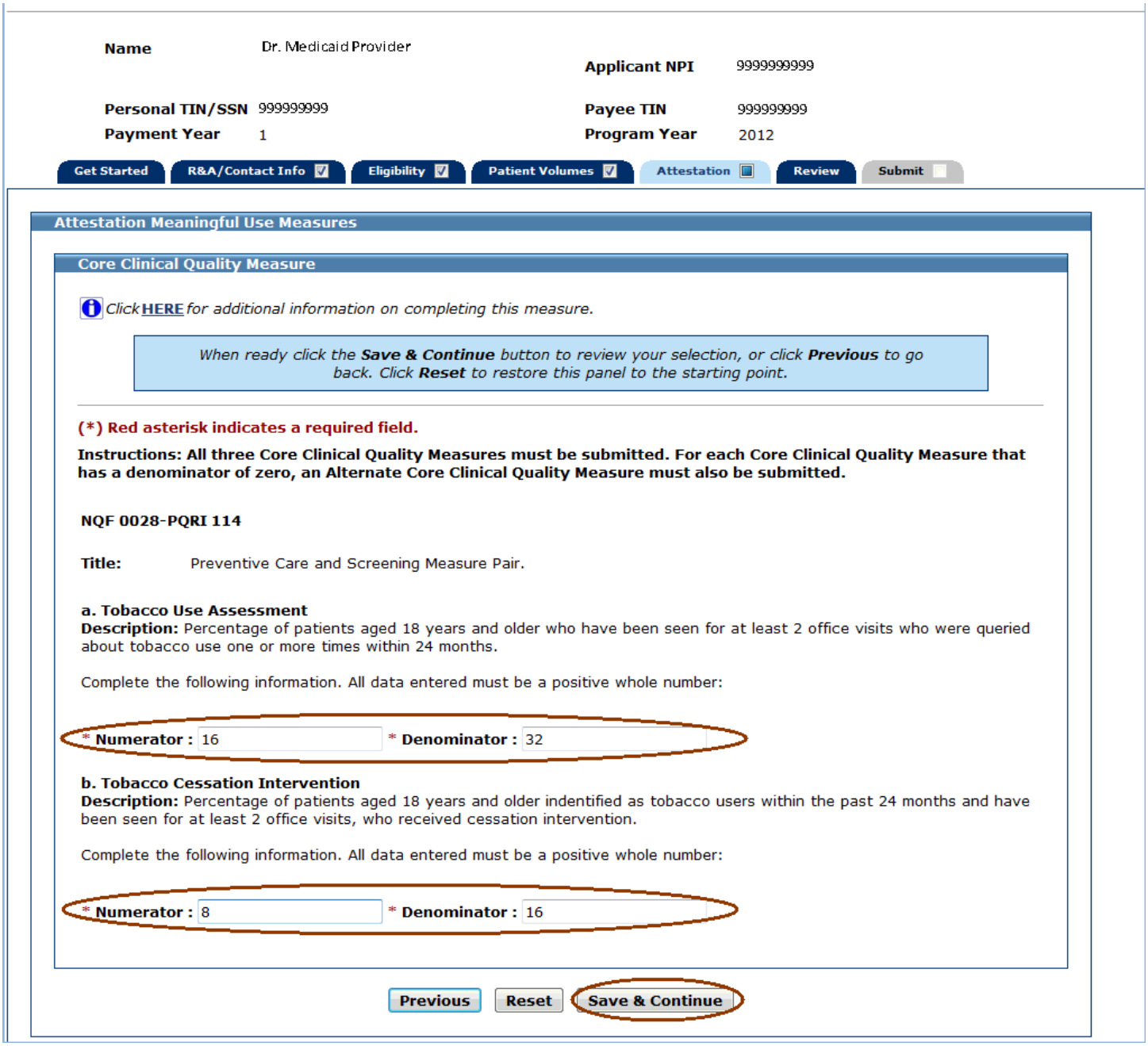
Attestation Meaningful Use Measures
Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0013
Title: Hypertension: Blood Pressure Measurement.
Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Complete the following information. All data entered must be a positive whole number:
* Numerator : 55
* Denominator : 100
Previous
Reset
Save & Continue

Core Clinical Quality Measure NQF 0028-PQRI 114

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
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Payee TIN
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Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
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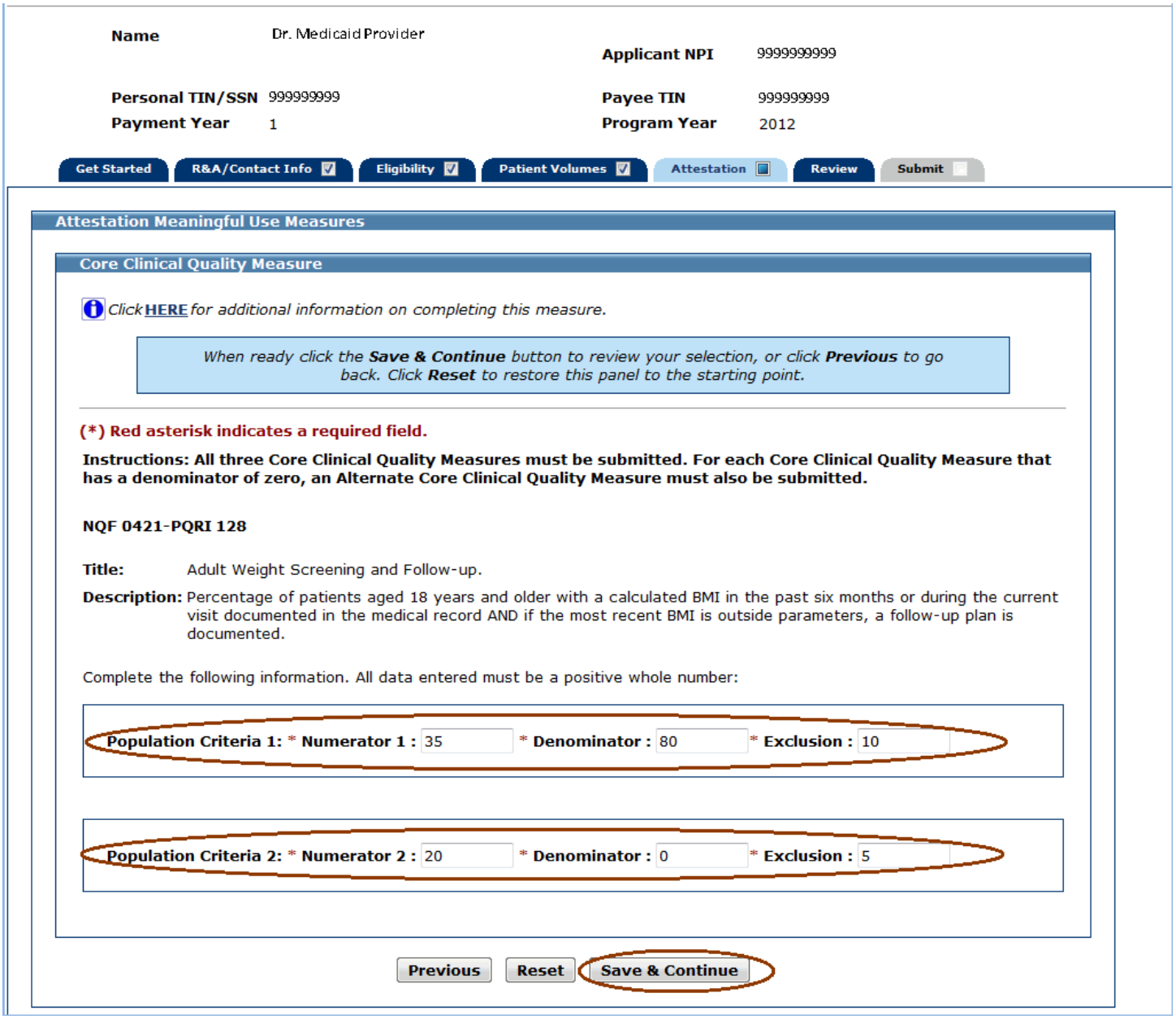
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0028-PQRI 114
Title:
Preventive Care and Screening Measure Pair.
a. Tobacco Use Assessment
Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.
Complete the following information. All data entered must be a positive whole number:
* Numerator : 16
* Denominator : 32
b. Tobacco Cessation Intervention
Description: Percentage of patients aged 18 years and older indentified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
Complete the following information. All data entered must be a positive whole number:
* Numerator : 8
* Denominator : 16
Previous
Reset
Save & Continue

Core Clinical Quality Measure NQF 0421-PQRI 128

Enter information in all required fields.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
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Payee TIN
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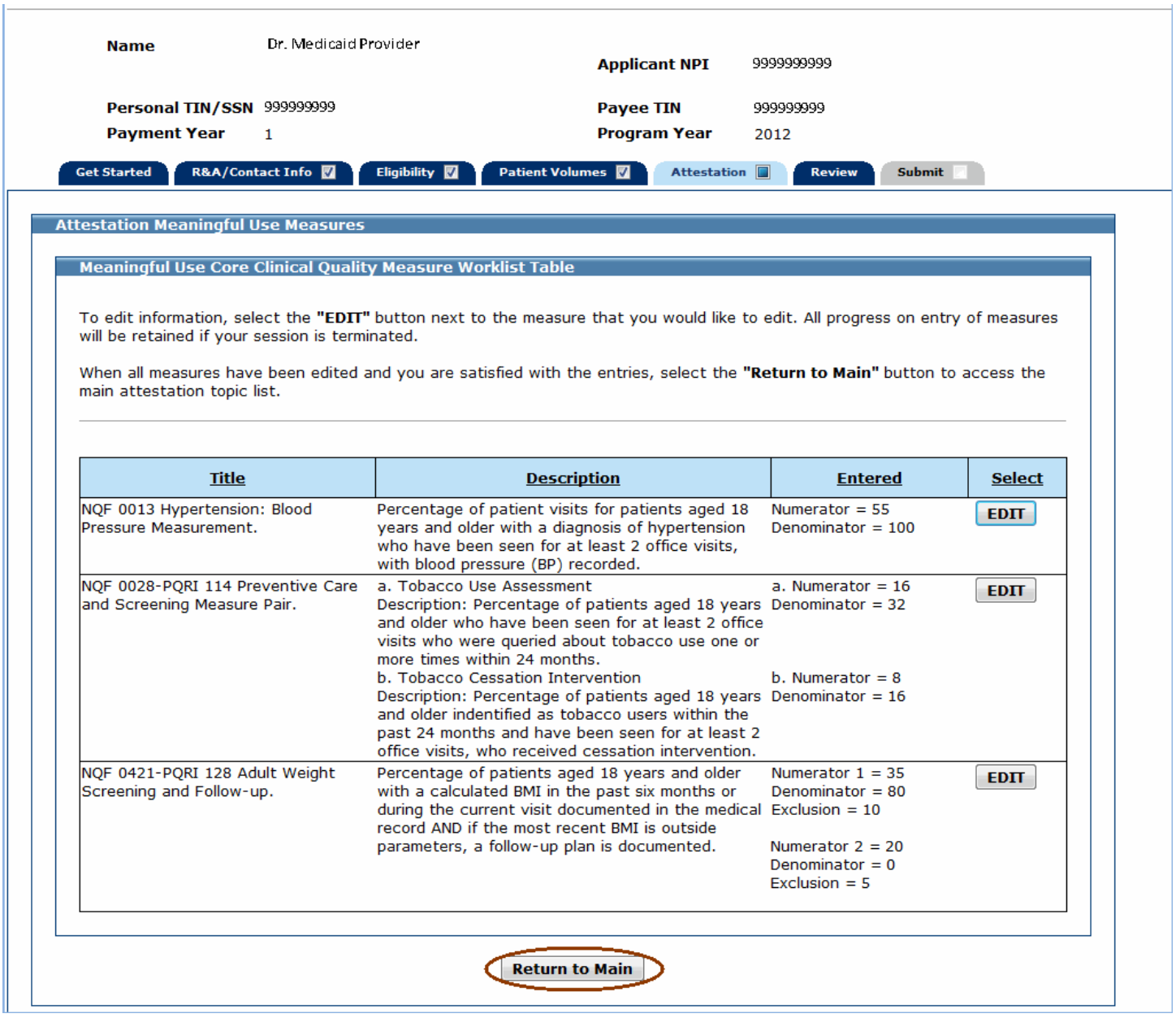
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0421-PQRI 128
Title:
Adult Weight Screening and Follow-up.
Description:
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
Complete the following information. All data entered must be a positive whole number:
Population Criteria 1: * Numerator 1 : 35 * Denominator : 80 * Exclusion : 10
Population Criteria 2: * Numerator 2 : 20 * Denominator : 0 * Exclusion : 5
Previous
Reset
Save & Continue

The following screen displays the Meaningful Use Core Clinical Quality Measures Worklist Table with data entered for every measure.

Click **Return to Main** to return to the Measures Topic List.


Name
Dr. Medicaid Provider
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Personal TIN/SSN
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Payee TIN
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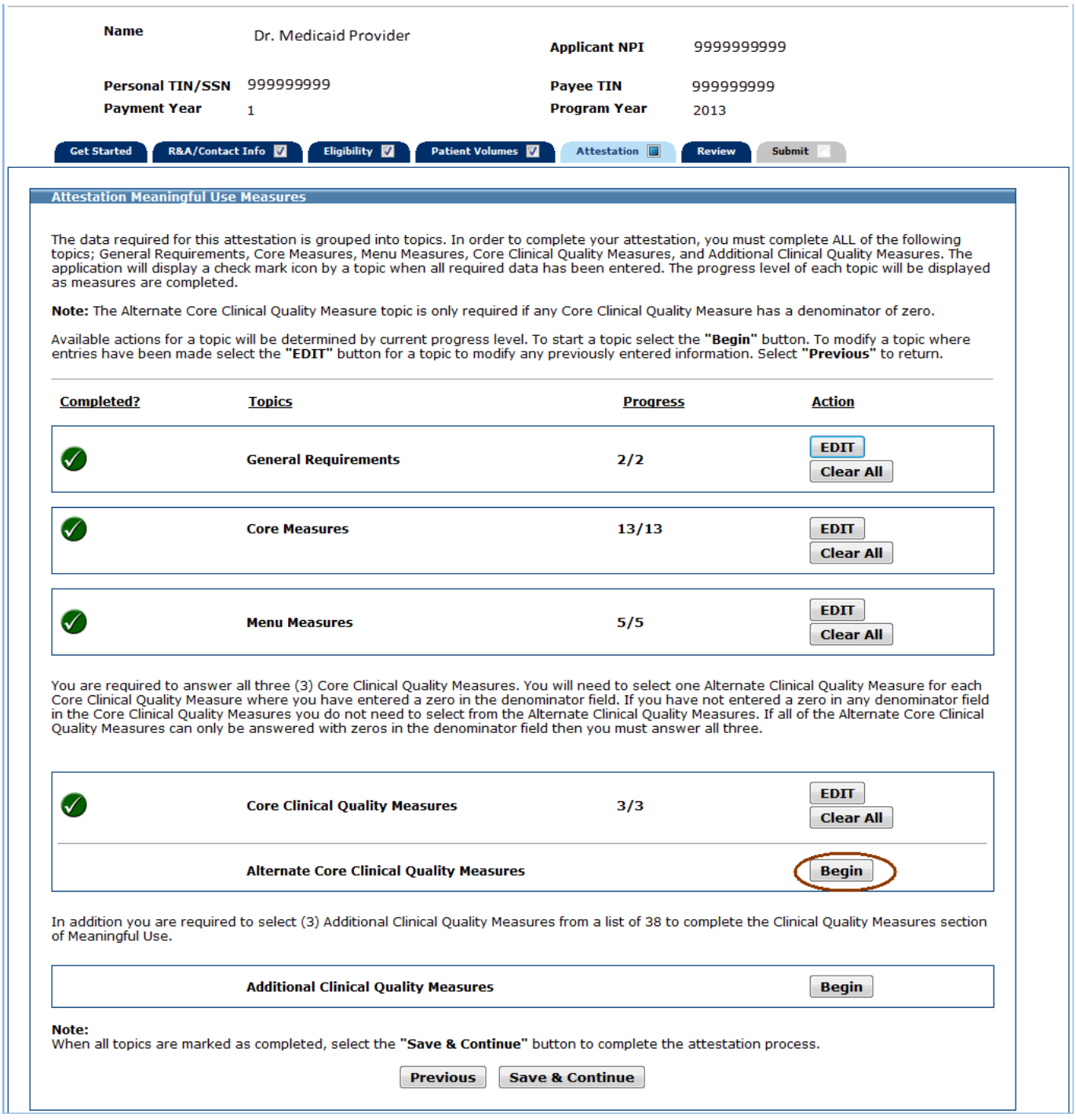
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Core Clinical Quality Measure Worklist Table
To edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Main" button to access the main attestation topic list.
Title
Description
Entered
Select
NQF 0013 Hypertension: Blood Pressure Measurement.
Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Numerator = 55
Denominator = 100
EDIT
NQF 0028-PQRI 114 Preventive Care and Screening Measure Pair.
a. Tobacco Use Assessment
Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.
b. Tobacco Cessation Intervention
Description: Percentage of patients aged 18 years and older indentified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
a. Numerator = 16
Denominator = 32
b. Numerator = 8
Denominator = 16
EDIT
NQF 0421-PQRI 128 Adult Weight Screening and Follow-up.
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
Numerator 1 = 35
Denominator = 80
Exclusion = 10
Numerator 2 = 20
Denominator = 0
Exclusion = 5
EDIT
Return to Main

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

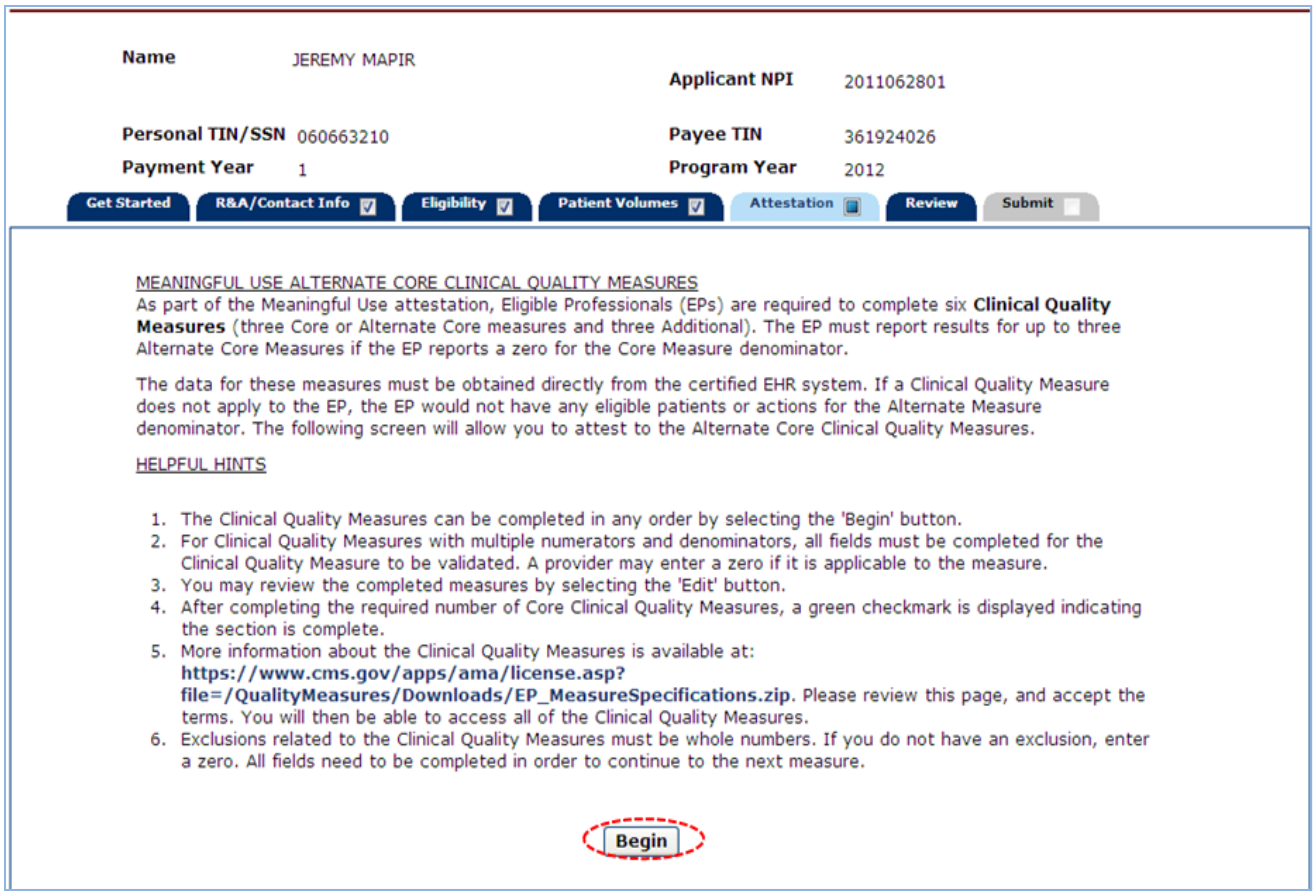
Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
13/13
EDIT
Clear All
Menu Measures
5/5
EDIT
Clear All
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures
3/3
EDIT
Clear All
Alternate Core Clinical Quality Measures
Begin
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Alternate Core Clinical Quality Measures

This initial screen provides information about the Alternate Core Clinical Quality Measures.

Click **Begin** to continue to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

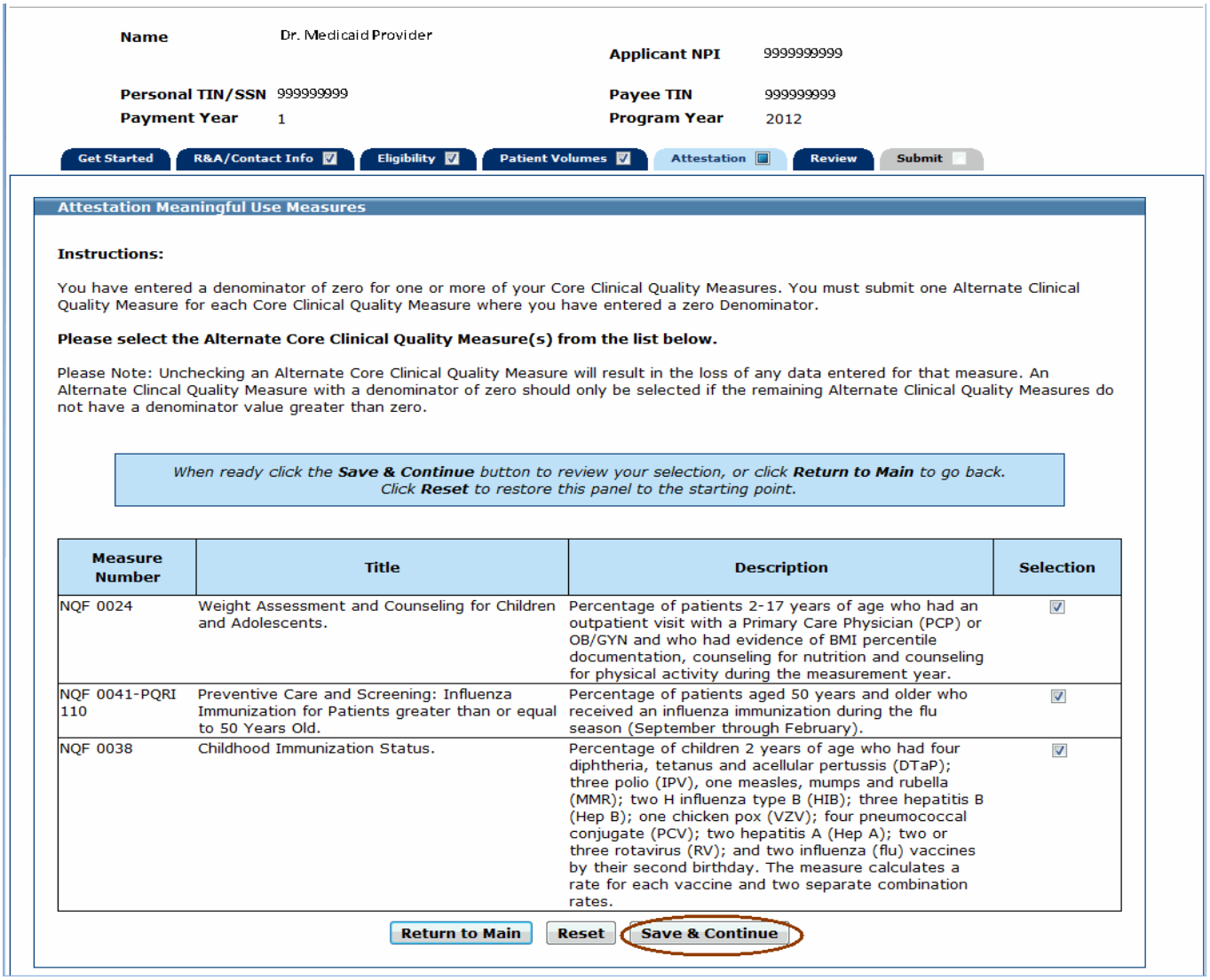

Name JEREMY MAPIR
Applicant NPI 2011062801
Personal TIN/SSN 060663210
Payee TIN 361924026
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE ALTERNATE CORE CLINICAL QUALITY MEASURES
As part of the Meaningful Use attestation, Eligible Professionals (EPs) are required to complete six Clinical Quality Measures (three Core or Alternate Core measures and three Additional). The EP must report results for up to three Alternate Core Measures if the EP reports a zero for the Core Measure denominator.
The data for these measures must be obtained directly from the certified EHR system. If a Clinical Quality Measure does not apply to the EP, the EP would not have any eligible patients or actions for the Alternate Measure denominator. The following screen will allow you to attest to the Alternate Core Clinical Quality Measures.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. For Clinical Quality Measures with multiple numerators and denominators, all fields must be completed for the Clinical Quality Measure to be validated. A provider may enter a zero if it is applicable to the measure.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing the required number of Core Clinical Quality Measures, a green checkmark is displayed indicating the section is complete.
5. More information about the Clinical Quality Measures is available at: https://www.cms.gov/apps/ama/license.asp?file=/QualityMeasures/Downloads/EP_MeasureSpecifications.zip. Please review this page, and accept the terms. You will then be able to access all of the Clinical Quality Measures.
6. Exclusions related to the Clinical Quality Measures must be whole numbers. If you do not have an exclusion, enter a zero. All fields need to be completed in order to continue to the next measure.
Begin

The following screen displays the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

You are only required to answer an Alternate Core Clinical Quality Measure if you entered a zero in a denominator field for a Core Clinical Quality Measure.

If you only enter zeros in the denominator fields for the Alternate Core Clinical Quality Measures, then you must attest to all three Alternate Core Clinical Quality measures to show that you were not able to attest to any of the Alternate Core Clinical Quality Measures with a value greater than zero in the denominator field.

Click on the checkbox next to the measure(s) you want to attest to. Click **Save & Continue** to proceed to the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table where you can review your selections. Click **Reset** to restore this panel to the starting point or last saved data. Click **Return to Main** to return to the Measures Topic List.

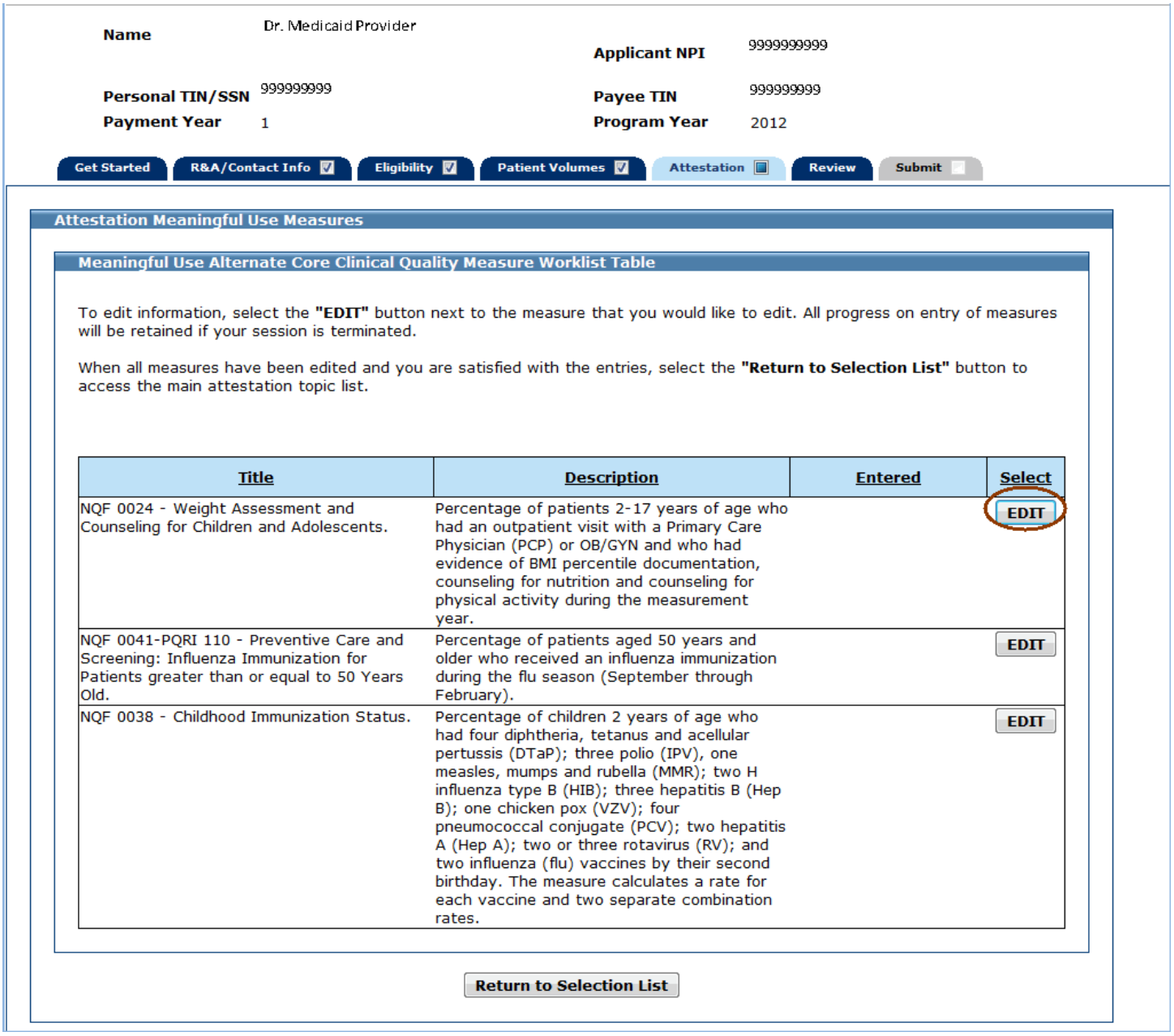

Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Instructions:
You have entered a denominator of zero for one or more of your Core Clinical Quality Measures. You must submit one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero Denominator.
Please select the Alternate Core Clinical Quality Measure(s) from the list below.
Please Note: Unchecking an Alternate Core Clinical Quality Measure will result in the loss of any data entered for that measure. An Alternate Clincal Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.
When ready click the Save & Continue button to review your selection, or click Return to Main to go back.
Click Reset to restore this panel to the starting point.
Measure Number
Title
Description
Selection
NQF 0024
Weight Assessment and Counseling for Children and Adolescents.
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
NQF 0041-PQRI 110
Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
NQF 0038
Childhood Immunization Status.
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Return to Main
Reset
Save & Continue

The 3 available Alternate Core Clinical Quality Measures are described in this user guide. Only those that you selected will apply to you.

The screen on the following page displays the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table which lists the measures you chose to attest to on the previous screen.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

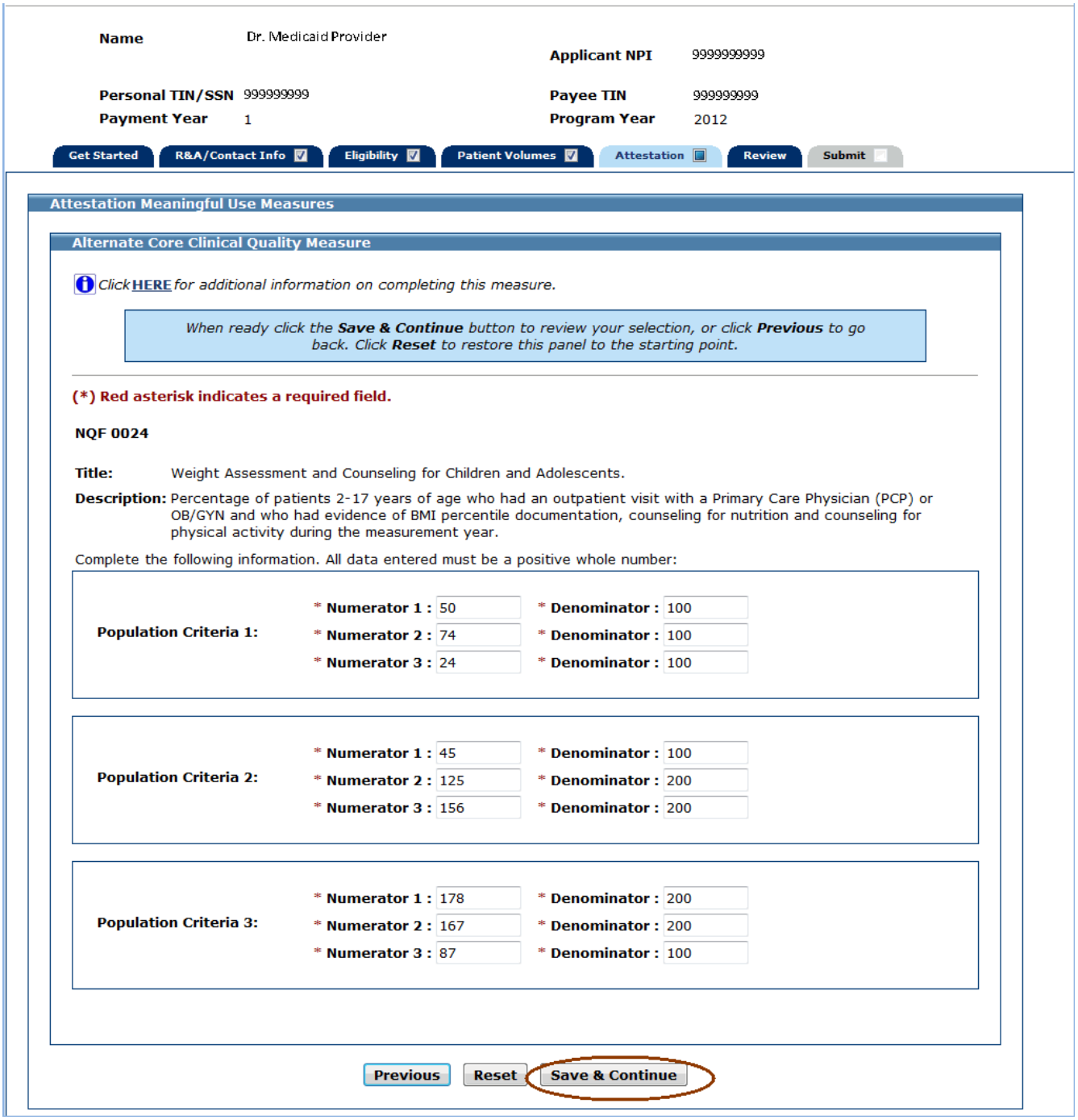
Click **Edit** to enter or edit information for the measure or click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Alternate Core Clinical Quality Measure Worklist Table
To edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Selection List" button to access the main attestation topic list.
Title
Description
Entered
Select
NQF 0024 - Weight Assessment and Counseling for Children and Adolescents.
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
EDIT
NQF 0041-PQRI 110 - Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
EDIT
NQF 0038 - Childhood Immunization Status.
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
EDIT
Return to Selection List

Alternate Core Clinical Quality Measure NQF 0024

Enter information in all required fields.

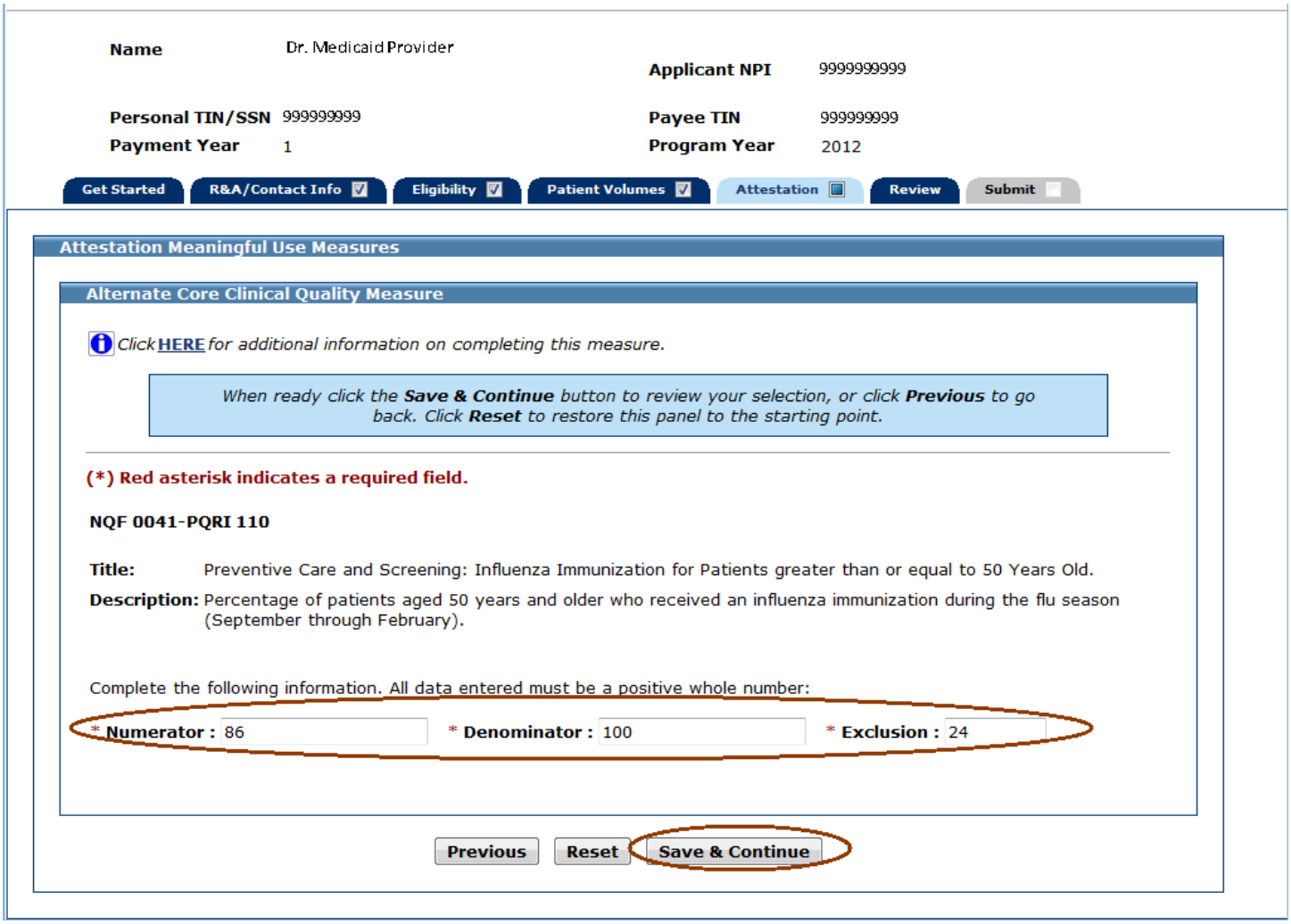
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Alternate Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
NQF 0024
Title:
Weight Assessment and Counseling for Children and Adolescents.
Description:
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
Complete the following information. All data entered must be a positive whole number:
Population Criteria 1:
* Numerator 1 : 50
* Denominator : 100
* Numerator 2 : 74
* Denominator : 100
* Numerator 3 : 24
* Denominator : 100
Population Criteria 2:
* Numerator 1 : 45
* Denominator : 100
* Numerator 2 : 125
* Denominator : 200
* Numerator 3 : 156
* Denominator : 200
Population Criteria 3:
* Numerator 1 : 178
* Denominator : 200
* Numerator 2 : 167
* Denominator : 200
* Numerator 3 : 87
* Denominator : 100
Previous
Reset
Save & Continue

Alternate Core Clinical Quality Measure NQF 0041-PQRI 110

Enter information in all required fields.

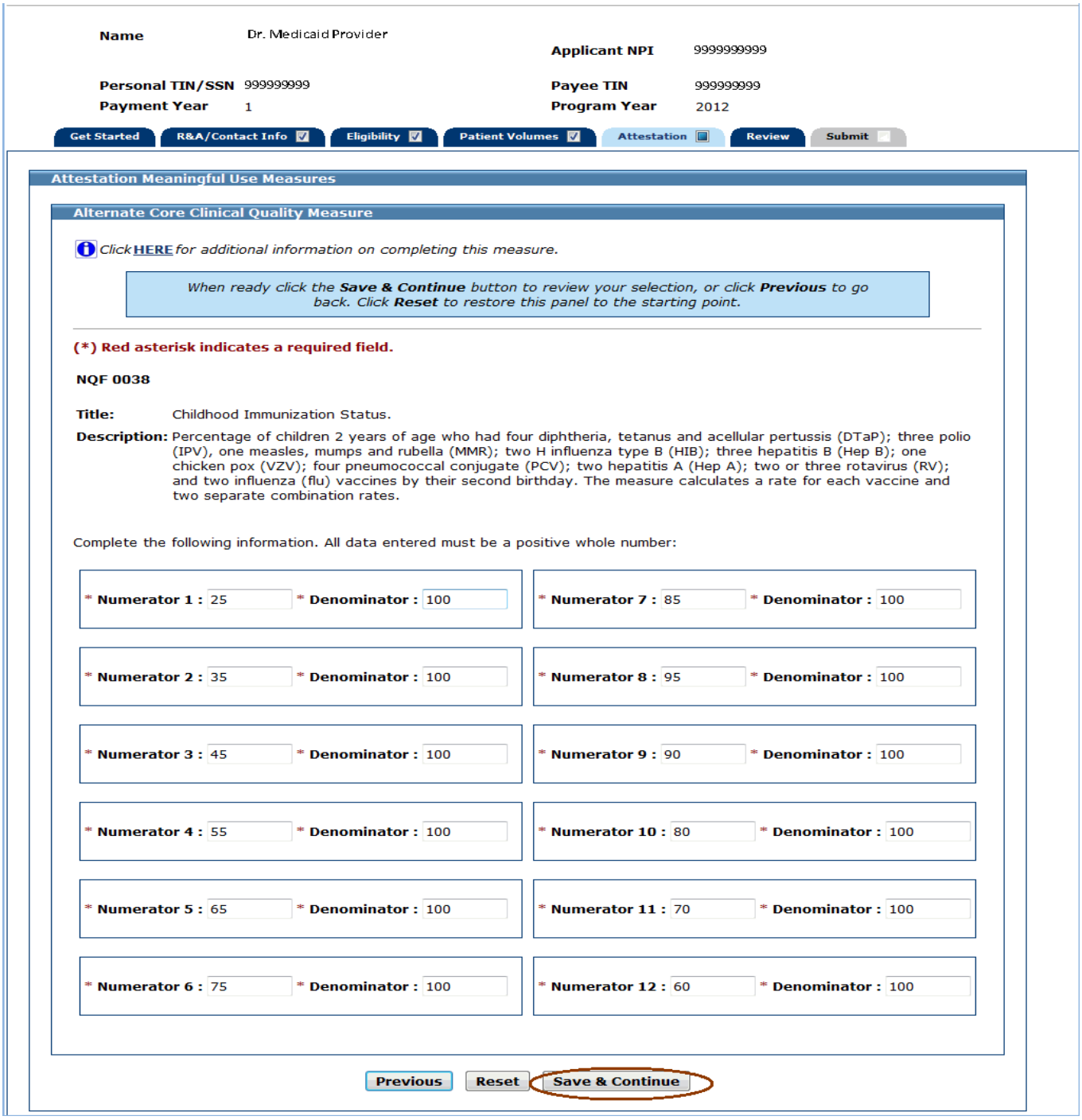
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Alternate Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
NQF 0041-PQRI 110
Title:
Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.
Description:
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
Complete the following information. All data entered must be a positive whole number:
* Numerator : 86
* Denominator : 100
* Exclusion : 24
Previous
Reset
Save & Continue

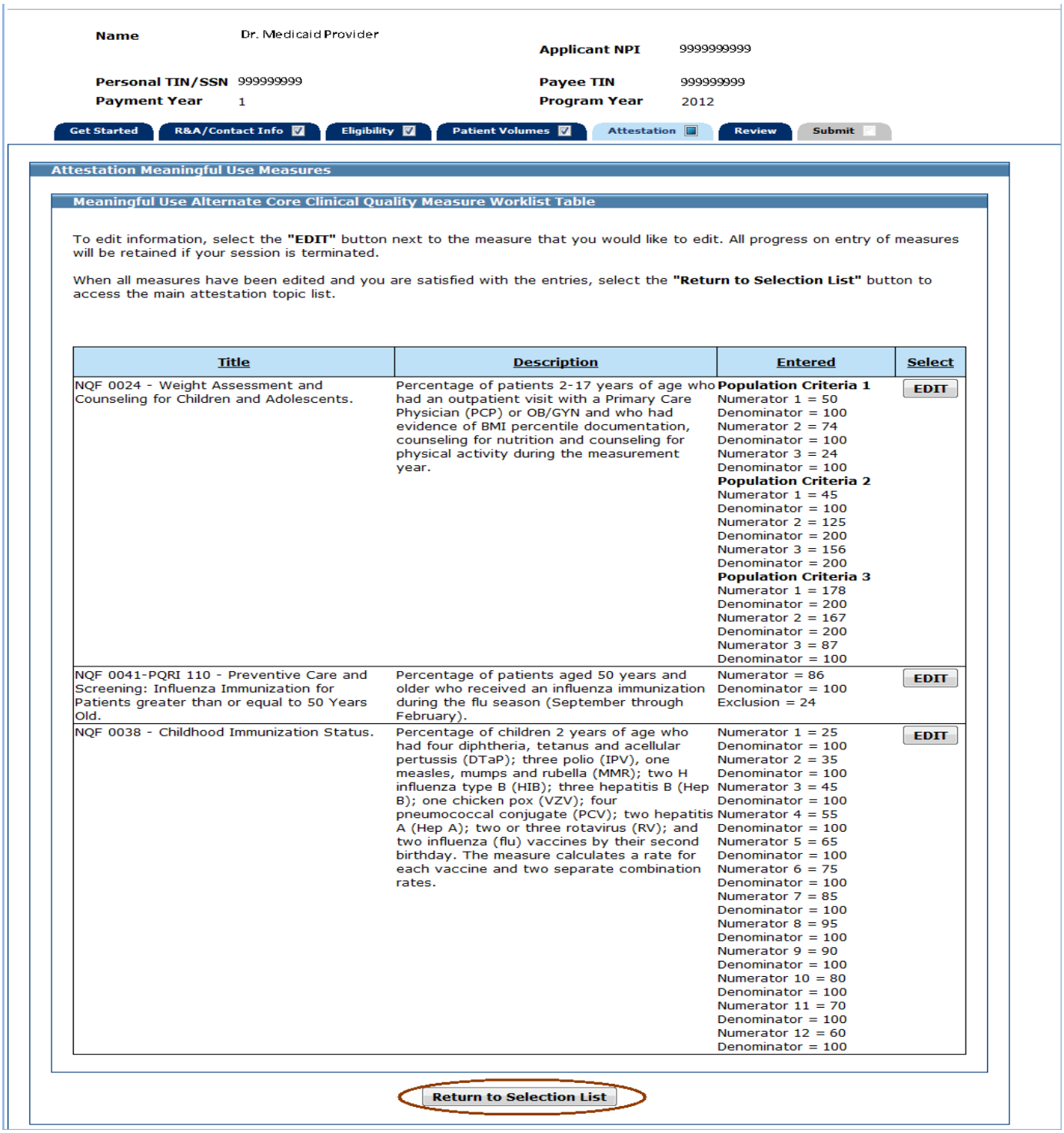
Alternate Core Clinical Quality Measure NQF 0038

Enter information in all required fields.

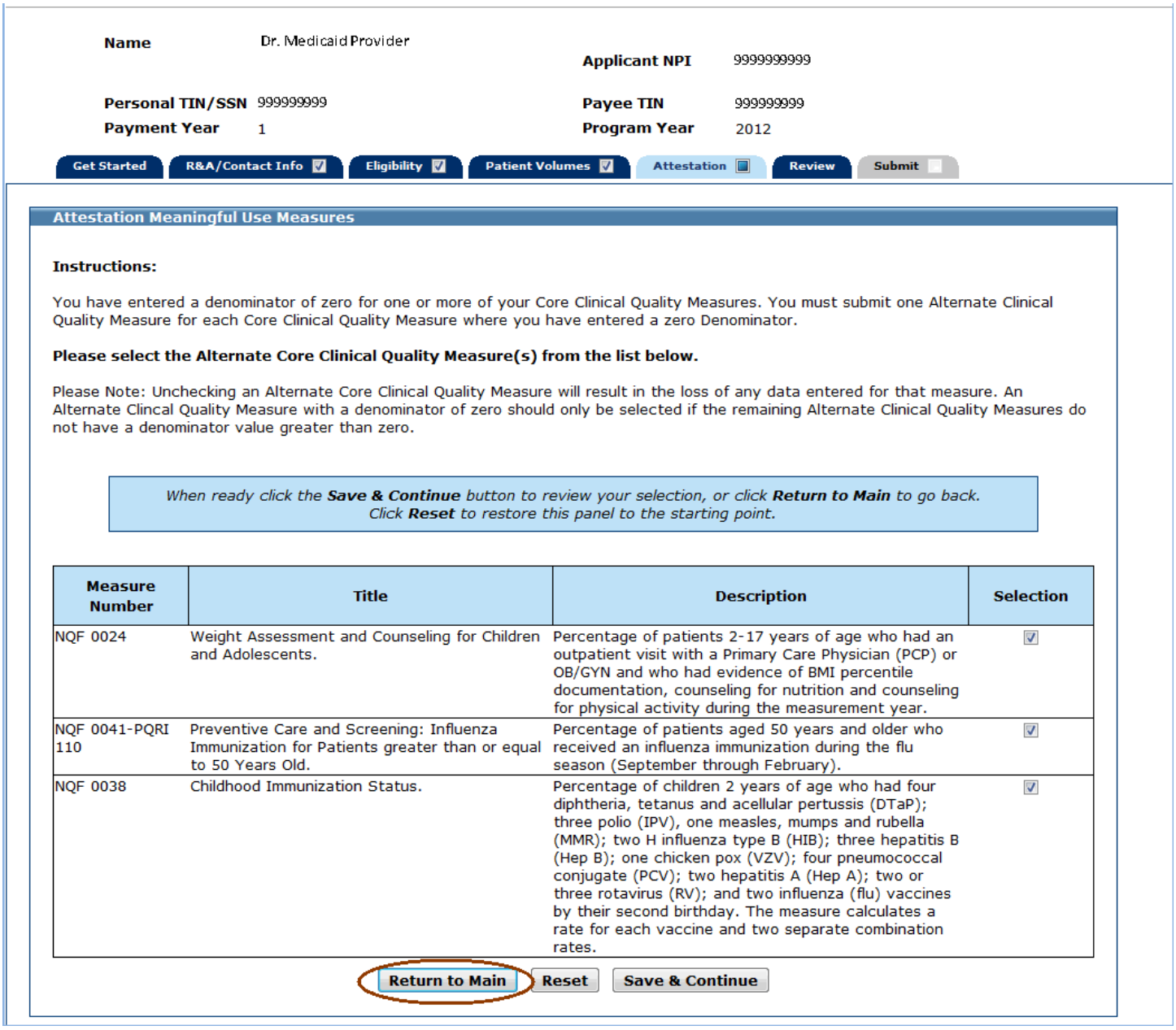
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Alternate Core Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
NQF 0038
Title:
Childhood Immunization Status.
Description:
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Complete the following information. All data entered must be a positive whole number:
* Numerator 1 : 25 * Denominator : 100
* Numerator 7 : 85 * Denominator : 100
* Numerator 2 : 35 * Denominator : 100
* Numerator 8 : 95 * Denominator : 100
* Numerator 3 : 45 * Denominator : 100
* Numerator 9 : 90 * Denominator : 100
* Numerator 4 : 55 * Denominator : 100
* Numerator 10 : 80 * Denominator : 100
* Numerator 5 : 65 * Denominator : 100
* Numerator 11 : 70 * Denominator : 100
* Numerator 6 : 75 * Denominator : 100
* Numerator 12 : 60 * Denominator : 100
Previous
Reset
Save & Continue

Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

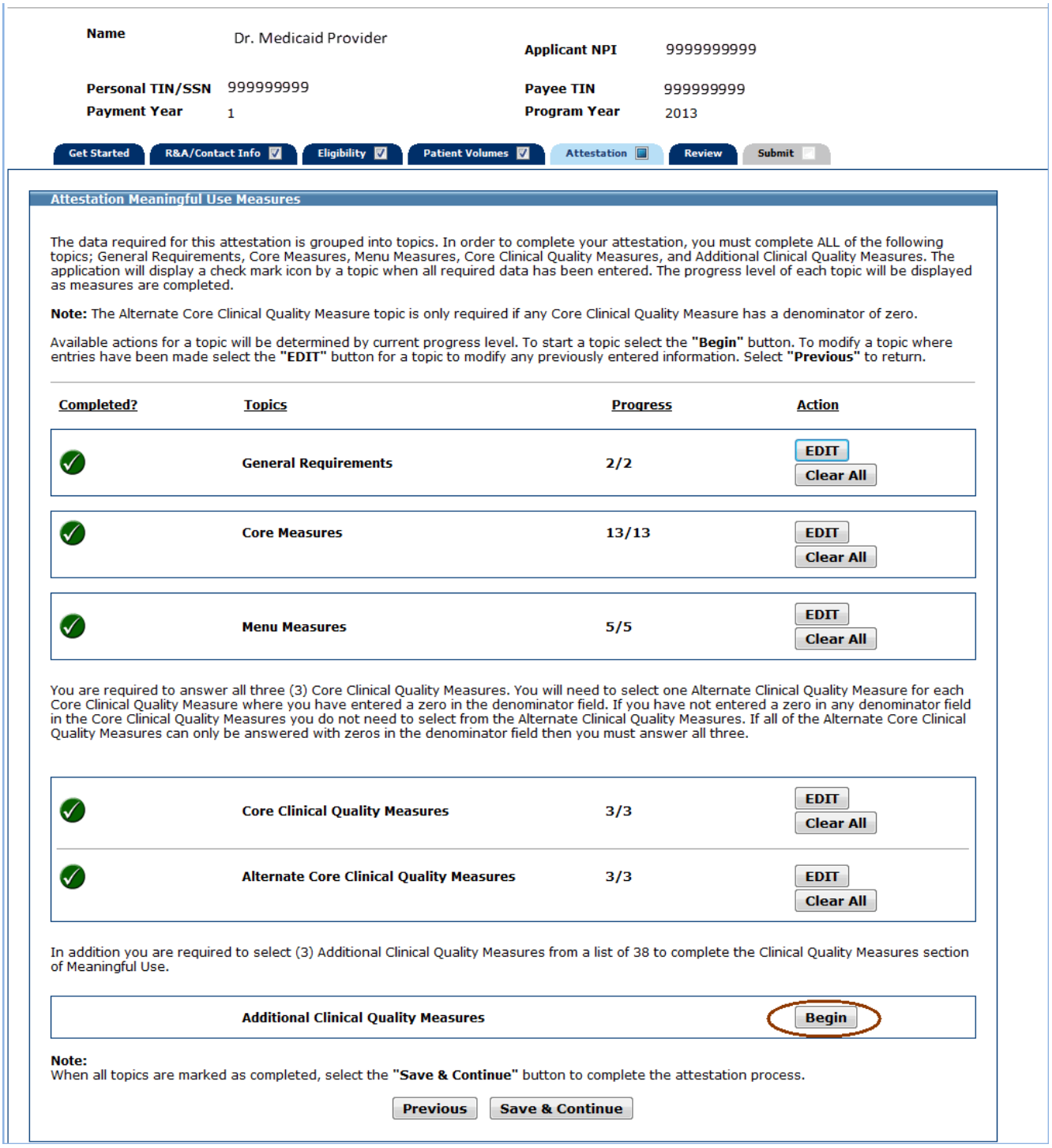

Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Alternate Core Clinical Quality Measure Worklist Table
To edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Selection List" button to access the main attestation topic list.
Title
Description
Entered
Select
NQF 0024 - Weight Assessment and Counseling for Children and Adolescents.
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
Population Criteria 1
Numerator 1 = 50
Denominator = 100
Numerator 2 = 74
Denominator = 100
Numerator 3 = 24
Denominator = 100
Population Criteria 2
Numerator 1 = 45
Denominator = 100
Numerator 2 = 125
Denominator = 200
Numerator 3 = 156
Denominator = 200
Population Criteria 3
Numerator 1 = 178
Denominator = 200
Numerator 2 = 167
Denominator = 200
Numerator 3 = 87
Denominator = 100
EDIT
NQF 0041-PQRI 110 - Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
Numerator = 86
Denominator = 100
Exclusion = 24
EDIT
NQF 0038 - Childhood Immunization Status.
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Numerator 1 = 25
Denominator = 100
Numerator 2 = 35
Denominator = 100
Numerator 3 = 45
Denominator = 100
Numerator 4 = 55
Denominator = 100
Numerator 5 = 65
Denominator = 100
Numerator 6 = 75
Denominator = 100
Numerator 7 = 85
Denominator = 100
Numerator 8 = 95
Denominator = 100
Numerator 9 = 90
Denominator = 100
Numerator 10 = 80
Denominator = 100
Numerator 11 = 70
Denominator = 100
Numerator 12 = 60
Denominator = 100
EDIT
Return to Selection List

Click **Return to Main** to return to the Measure Topic List.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Instructions:
You have entered a denominator of zero for one or more of your Core Clinical Quality Measures. You must submit one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero Denominator.
Please select the Alternate Core Clinical Quality Measure(s) from the list below.
Please Note: Unchecking an Alternate Core Clinical Quality Measure will result in the loss of any data entered for that measure. An Alternate Clincal Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.
When ready click the Save & Continue button to review your selection, or click Return to Main to go back.
Click Reset to restore this panel to the starting point.
Measure Number
Title
Description
Selection
NQF 0024
Weight Assessment and Counseling for Children and Adolescents.
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
NQF 0041-PQRI 110
Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.
Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
NQF 0038
Childhood Immunization Status.
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Return to Main
Reset
Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

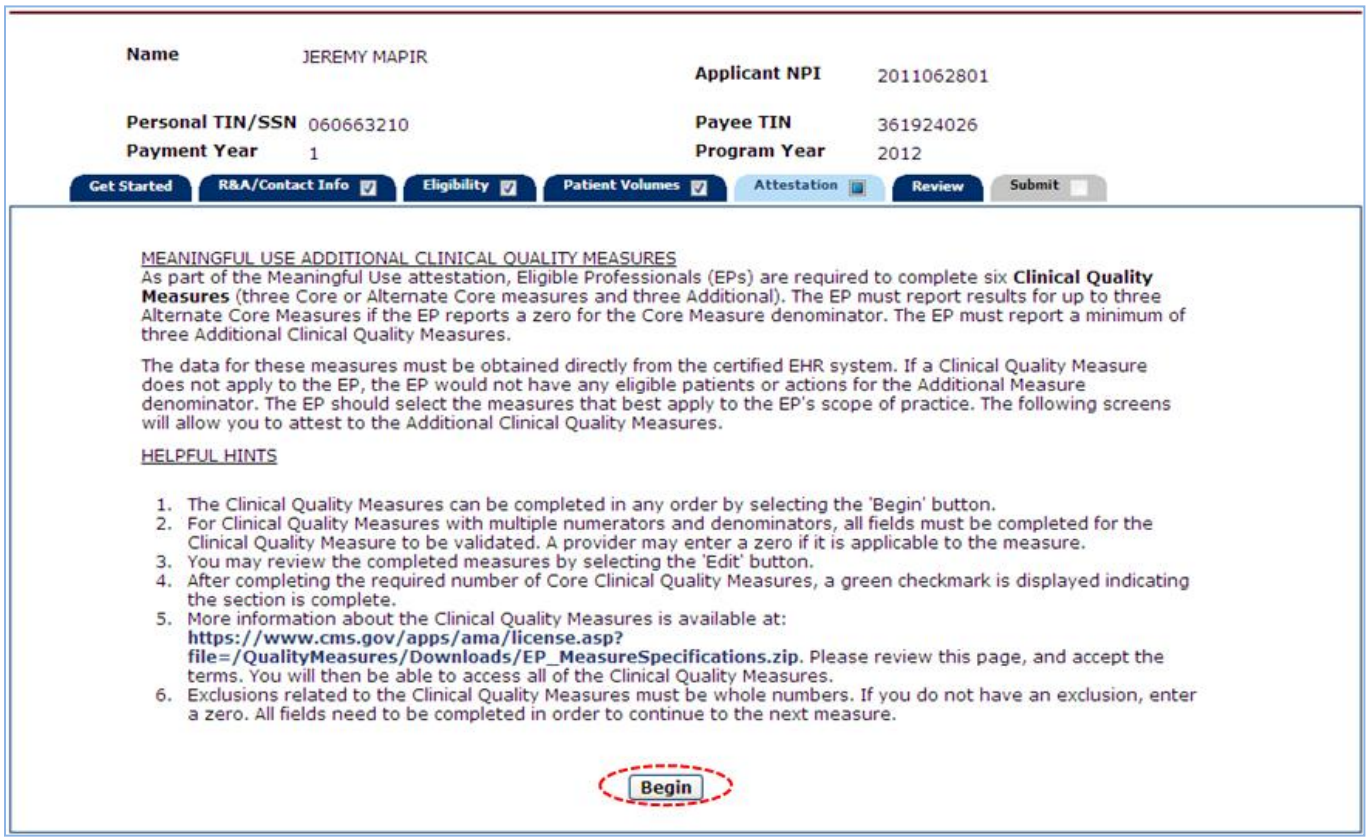
Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2013
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.
Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
General Requirements
2/2
EDIT
Clear All
Core Measures
13/13
EDIT
Clear All
Menu Measures
5/5
EDIT
Clear All
You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.
Core Clinical Quality Measures
3/3
EDIT
Clear All
Alternate Core Clinical Quality Measures
3/3
EDIT
Clear All
In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.
Additional Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Additional Clinical Quality Measures

This initial screen provides information about the Additional Clinical Quality Measures.

Click **Begin** to continue to the Meaningful Use Additional Clinical Quality Measures Selection screen.


Name
JEREMY MAPIR
Applicant NPI
2011062801
Personal TIN/SSN
060663210
Payee TIN
361924026
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
MEANINGFUL USE ADDITIONAL CLINICAL QUALITY MEASURES
As part of the Meaningful Use attestation, Eligible Professionals (EPs) are required to complete six Clinical Quality Measures (three Core or Alternate Core measures and three Additional). The EP must report results for up to three Alternate Core Measures if the EP reports a zero for the Core Measure denominator. The EP must report a minimum of three Additional Clinical Quality Measures.
The data for these measures must be obtained directly from the certified EHR system. If a Clinical Quality Measure does not apply to the EP, the EP would not have any eligible patients or actions for the Additional Measure denominator. The EP should select the measures that best apply to the EP's scope of practice. The following screens will allow you to attest to the Additional Clinical Quality Measures.
HELPFUL HINTS
1. The Clinical Quality Measures can be completed in any order by selecting the 'Begin' button.
2. For Clinical Quality Measures with multiple numerators and denominators, all fields must be completed for the Clinical Quality Measure to be validated. A provider may enter a zero if it is applicable to the measure.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing the required number of Core Clinical Quality Measures, a green checkmark is displayed indicating the section is complete.
5. More information about the Clinical Quality Measures is available at: https://www.cms.gov/apps/ama/license.asp?file=/QualityMeasures/Downloads/EP_MeasureSpecifications.zip. Please review this page, and accept the terms. You will then be able to access all of the Clinical Quality Measures.
6. Exclusions related to the Clinical Quality Measures must be whole numbers. If you do not have an exclusion, enter a zero. All fields need to be completed in order to continue to the next measure.
Begin

The screens on the following pages display the Meaningful Use Additional Clinical Quality Measures Selection screen.

You are required to answer three Additional Clinical Quality Measures. There are a total of 38 Additional Clinical Quality Measures to choose from.

Click on the checkbox next to the measures you want to attest to, click **Save & Continue** to review your selections, or click **Reset** to restore this panel to the starting point or last saved data.

Meaningful Use Additional Clinical Quality Measures Selection screen (Part 1 of 3)

Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999

Payee TIN 999999999

Payment Year 1

Program Year 2012

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Attestation Meaningful Use Measures

Instructions:

Select three(3) Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the **Save & Continue** button below.

Measure#	Title	Description	Selection
NQF 0059-PQRI 1	Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.	☑
NQF 0064-PQRI 2	Diabetes: Low Density Lipoprotein (LDL) Management and Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.	☑
NQF 0061-PQRI 3	Diabetes: Blood Pressure Management.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.	☑
NQF 0081-PQRI 5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF less than 40%) who were prescribed ACE inhibitor or ARB therapy.	☐
NQF 0070-PQRI 7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD patients with prior Myocardial Infarction (MI).	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	☐
NQF 0043-PQRI 111	Pneumonia Vaccination Status for Older Adults.	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	☐
NQF 0031-PQRI 112	Breast Cancer Screening.	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	☐
NQF 0034-PQRI 113	Colorectal Cancer Screening.	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	☐
NQF 0067-PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	☐
NQF 0083-PQRI 8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF less than 40%) who were prescribed beta-blocker therapy.	☐
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment.	Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.	☐
NQF 0086-PQRI 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.	☐
NQF 0088-PQRI 18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	Percentage of patients aged 18 years and older with diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	☐

Meaningful Use Additional Clinical Quality Measures Selection screen (Part 2 of 3)

NQF 0089-PQRI 19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus at least once within 12 months.	☐
NQF 0047-PQRI 53	Asthma Pharmacologic Therapy.	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	☐
NQF 0002-PQRI 66	Appropriate Testing for Children with Pharyngitis.	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	☐
NQF 0387-PQRI 71	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	☐
NQF 0385-PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.	☐
NQF 0389-PQRI 102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	☐
NQF 0027-PQRI 115	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies.	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	☐
NQF 0055-PQRI 117	Diabetes: Eye Exam.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	☐
NQF 0062-PQRI 119	Diabetes: Urine Screening.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	☐
NQF 0056-PQRI 163	Diabetes: Foot Exam.	The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	☐
NQF 0074-PQRI 197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	☐
NQF 0084-PQRI 200	Heart Failure(HF): Warfarin Therapy patients with Atrial Fibrillation.	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	☐
NQF 0073-PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (less than 140/90 mmHg).	☐
NQF 0068-PQRI 204	Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic.	Percentage of patients 18 years of age or older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	☐

Meaningful Use Additional Clinical Quality Measures Selection screen (Part 3 of 3)

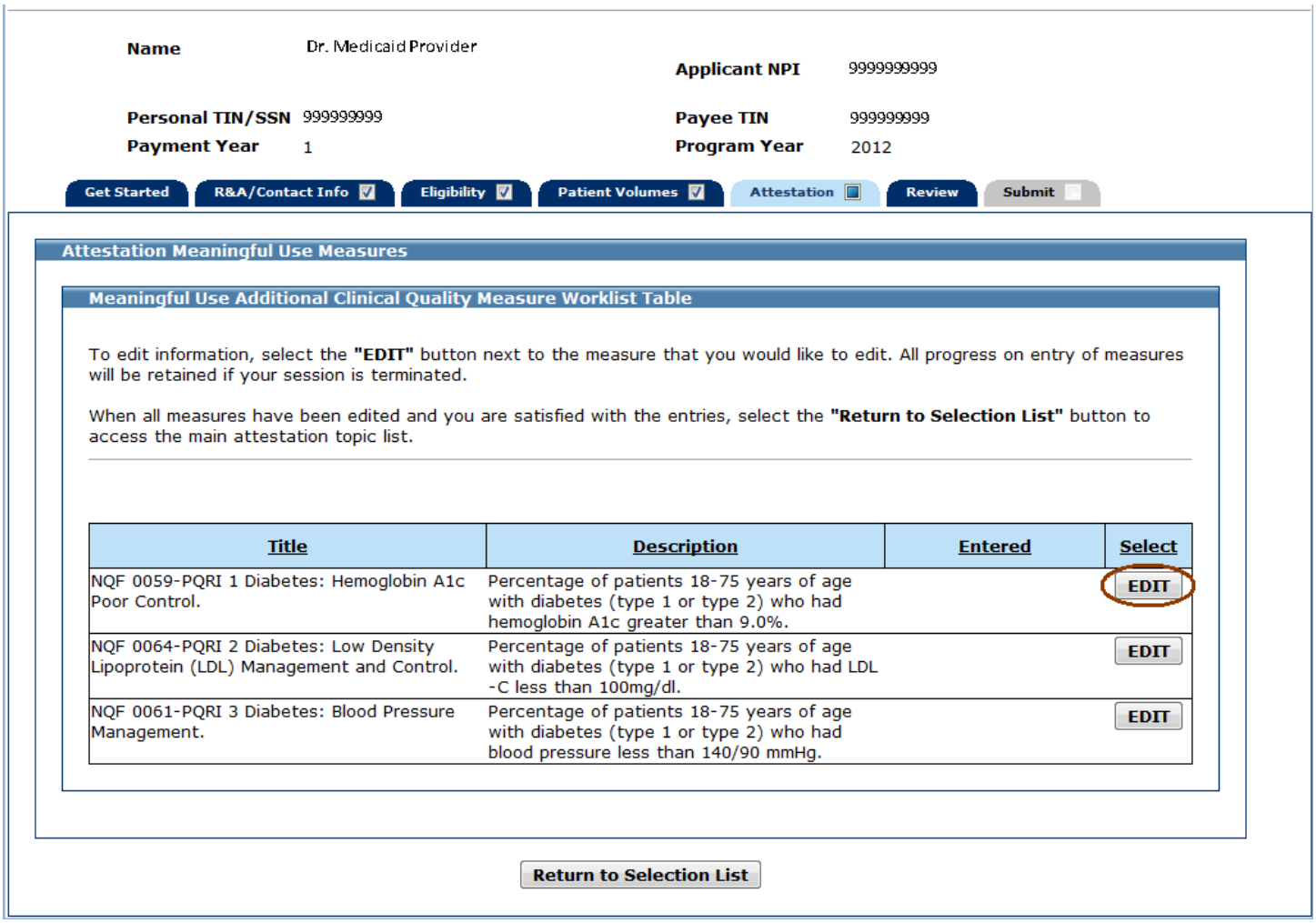
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement.	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	☐
NQF 0001-PQRI 64	Asthma Assessment.	Percentage of patient aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	☐
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV).	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.	☐
NQF 0014	Prenatal Care: Anti-D Immune Globulin.	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	☐
NQF 0018	Controlling High Blood Pressure.	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	☐
NQF 0032	Cervical Cancer Screening.	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	☐
NQF 0033	Chlamydia Screening for women.	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	☐
NQF 0036	Use of Appropriate Medications for Asthma.	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).	☐
NQF 0052	Low Back Pain: Use of Imaging Studies.	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	☐
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was less than 100 mg/dl.	☐
NQF 0575	Diabetes: Hemoglobin A1c (less than 8.0%).	The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%.	☐

Return to Main | Reset | Save & Continue

The following screen displays the Meaningful Use Additional Clinical Quality Measure Worklist Table with the Additional Clinical Quality Measures you selected to attest to.

Click **Edit** to enter or edit information for a measure or click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Additional Clinical Quality Measure Worklist Table
To edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Selection List" button to access the main attestation topic list.
Title
Description
Entered
Select
NQF 0059-PQRI 1 Diabetes: Hemoglobin A1c Poor Control.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.
EDIT
NQF 0064-PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL -C less than 100mg/dl.
EDIT
NQF 0061-PQRI 3 Diabetes: Blood Pressure Management.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.
EDIT
Return to Selection List

The following is a list of the Additional Clinical Quality Measures that you must attest to.

Click on the Screen Example to see an example of the screen layout.

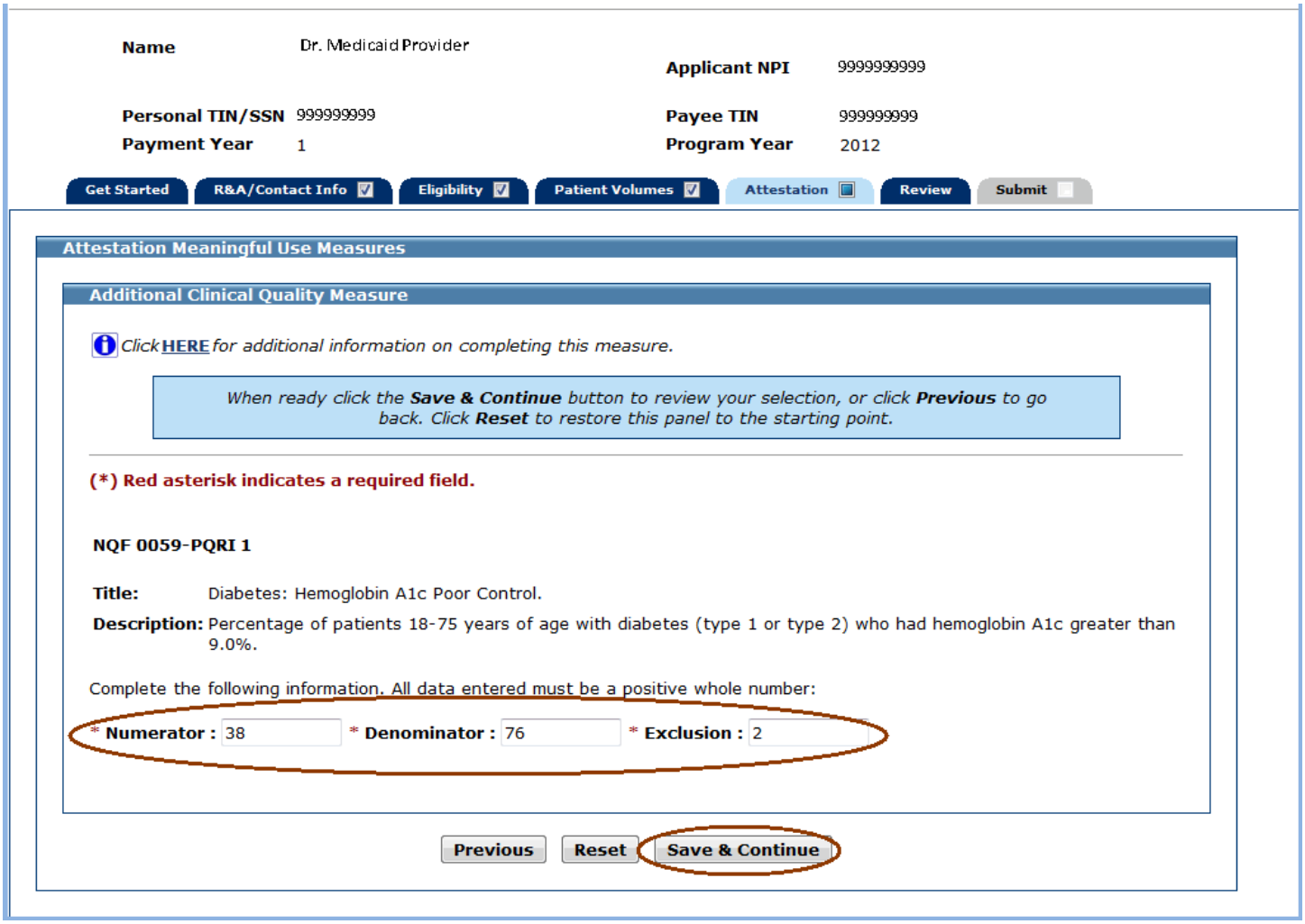
Additional Clinical Quality Measure	Screen Example
NQF 0059-PQRI 1	Screen 1
NQF 0064-PQRI 2	Screen 1
NQF 0061-PQRI 3	Screen 1
NQF 0081-PQRI 5	Screen 1
NQF 0070-PQRI 7	Screen 1
NQF 0043-PQRI 111	Screen 2
NQF 0031-PQRI 112	Screen 2
NQF 0034-PQRI 113	Screen 1
NQF 0067-PQRI 6	Screen 1
NQF 0083-PQRI 8	Screen 1
NQF 0105	Screen 3
NQF 0086-PQRI 12	Screen 1
NQF 0088-PQRI 18	Screen 1
NQF 0089-PQRI 19	Screen 1
NQF 0047-PQRI 53	Screen 1
NQF 0002-PQRI 66	Screen 2
NQF 0387-PQRI 71	Screen 1
NQF 0385-PQRI 72	Screen 1
NQF 0389-PQRI 102	Screen 1
NQF 0027-PQRI 115	Screen 3
NQF 0055-PQRI 117	Screen 1
NQF 0062-PQRI 119	Screen 1
NQF 0056-PQRI 163	Screen 1
NQF 0074-PQRI 197	Screen 1

Additional Clinical Quality Measure	Screen Example
NQF 0084-PQRI 200	Screen 1
NQF 0073-PQRI 201	Screen 2
NQF 0068-PQRI 204	Screen 2
NQF 0004	Screen 4
NQF 0001-PQRI 64	Screen 2
NQF 0012	Screen 1
NQF 0014	Screen 1
NQF 0018	Screen 2
NQF 0032	Screen 2
NQF 0033	Screen 4
NQF 0036	Screen 4
NQF 0052	Screen 2
NQF 0075	Screen 3
NQF 0575	Screen 1

Screen 1

The following Additional Clinical Quality Measures use this screen layout:

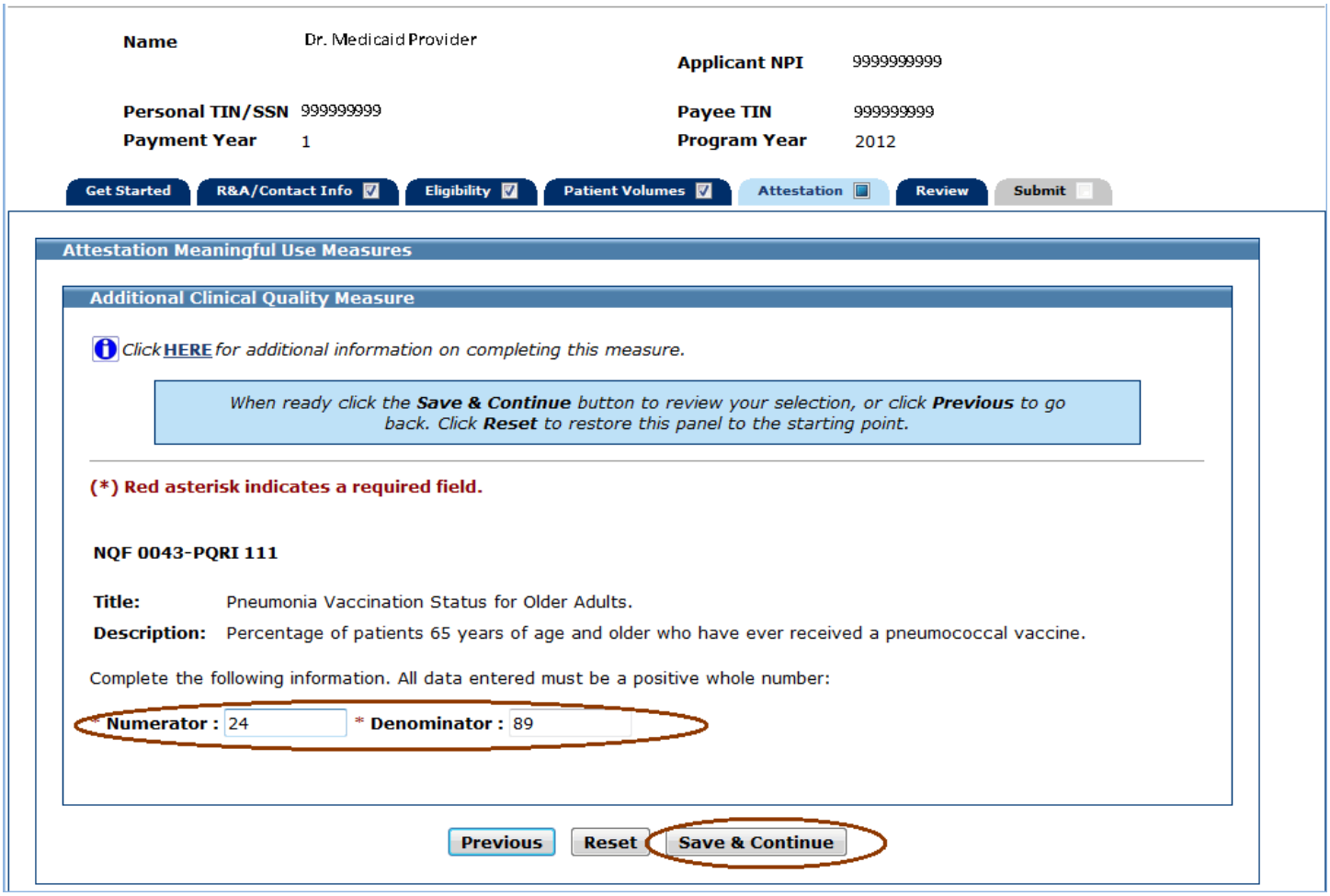
Additional Clinical Quality Measures NQF 0059-PQRI 1, NQF 0064-PQRI 2, NQF 0061-PQRI 3, NQF 0081-PQRI 5, NQF 0070-PQRI 7, NQF 0034-PQRI 113, NQF 0067-PQRI 6, NQF 0083-PQRI 8, NQF 0086-PQRI 12, NQF 0088-PQRI 18, NQF 0089-PQRI 19, NQF 0047-PQRI 53, NQF 0387-PQRI 71, NQF 0385-PQRI 72, NQF 0389-PQRI 102, NQF 0055-PQRI 117, NQF 0062-PQRI 119, NQF 0056-PQRI 163, NQF 0074-PQRI 197, NQF 0084-PQRI 200, NQF 0012, NQF 0014, and NQF 0575.



Screen 2

The following Additional Clinical Quality Measures use this screen layout:

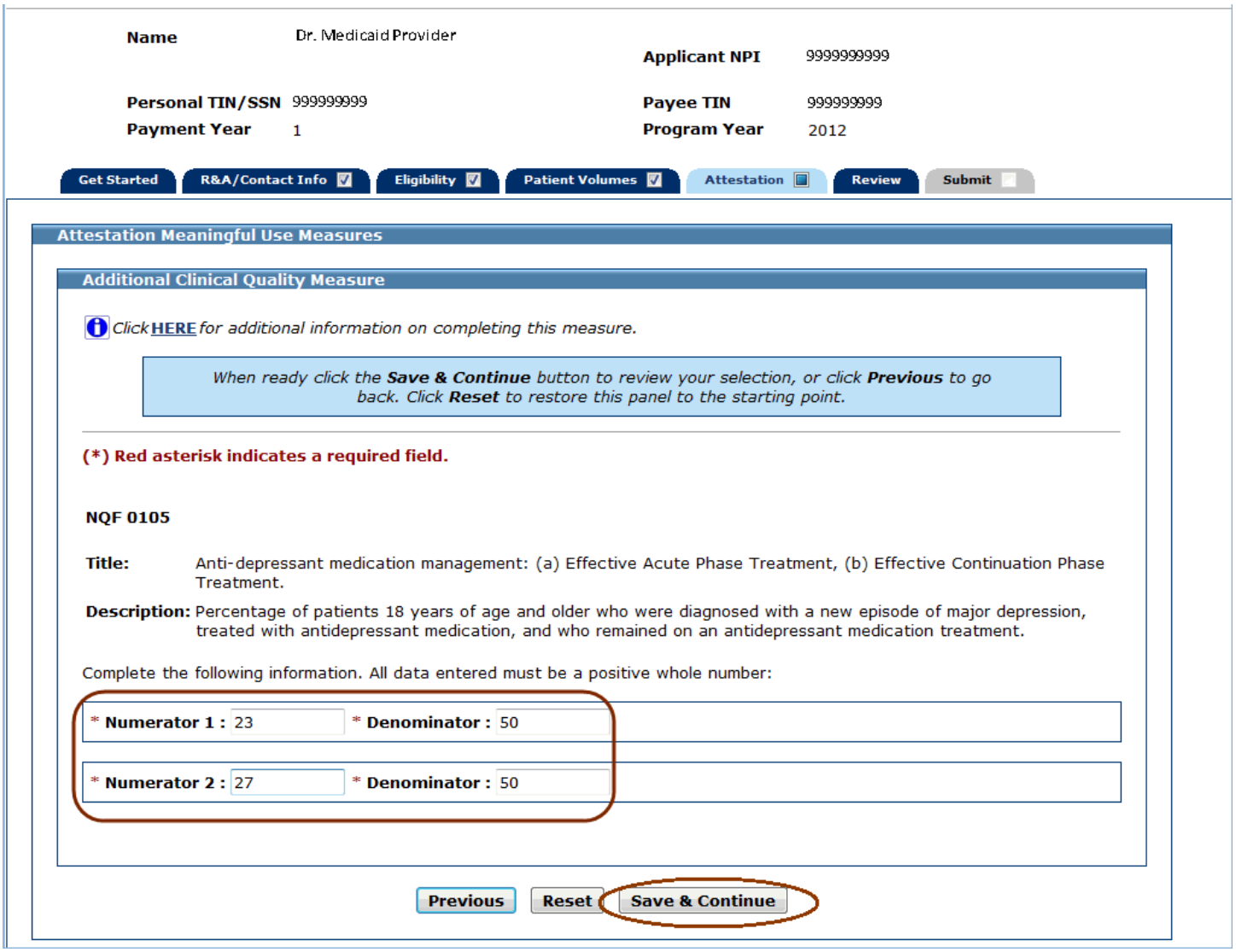
Additional Clinical Quality Measures NQF 0043-PQRI 111, NQF 0031-PQRI 112, NQF 0002-PQRI 66, NQF 0073-PQRI 201, NQF 0068-PQRI 204, NQF 0001-PQRI 64, NQF 0018, NQF 0032, and NQF 0052.



Screen 3

The following Additional Clinical Quality Measures use this screen layout:

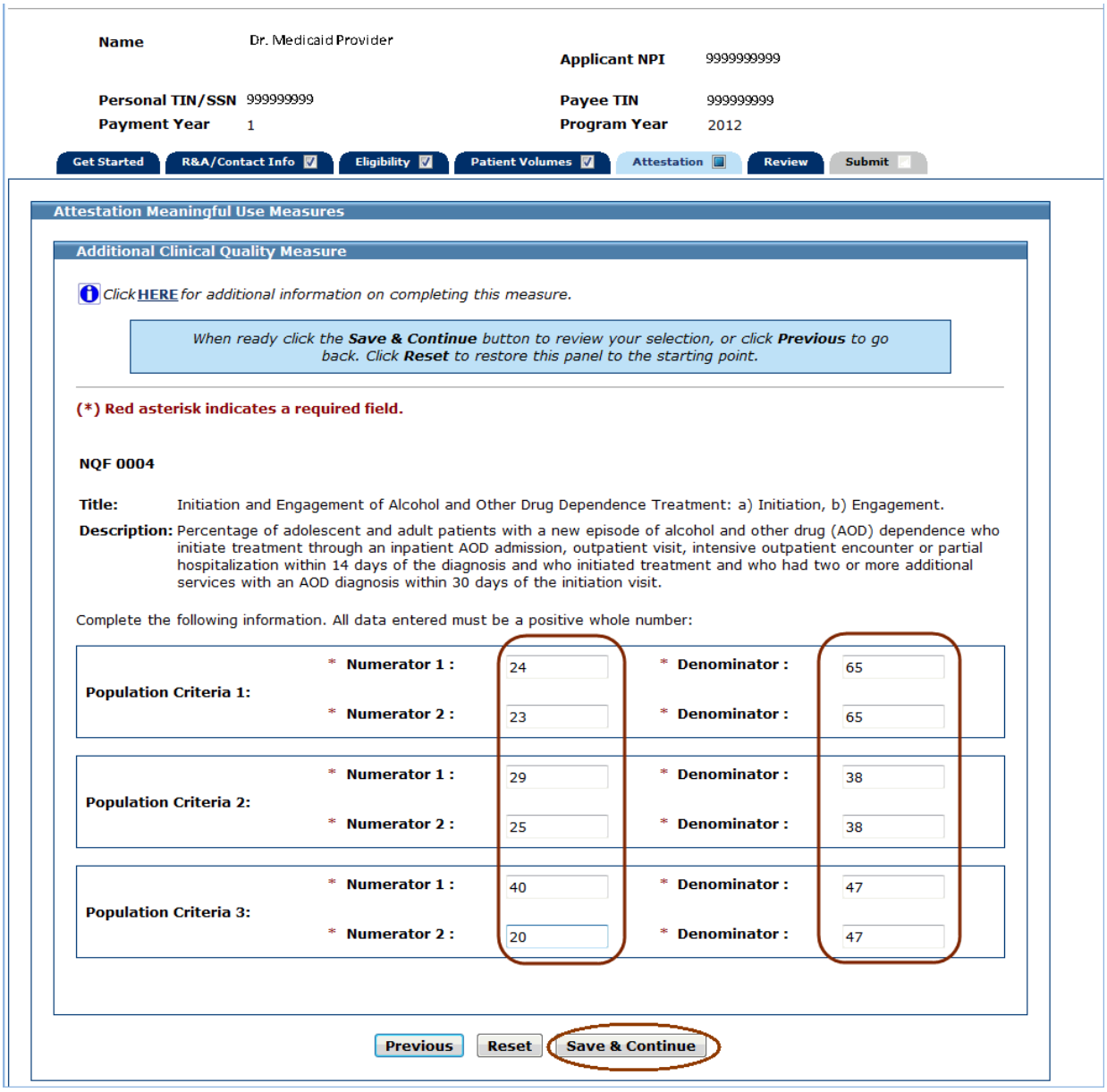
Additional Clinical Quality Measures NQF 0004, NQF 0033, and NQF 0036.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Additional Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
NQF 0105
Title:
Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment.
Description:
Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
Complete the following information. All data entered must be a positive whole number:
* Numerator 1 : 23
* Denominator : 50
* Numerator 2 : 27
* Denominator : 50
Previous
Reset
Save & Continue

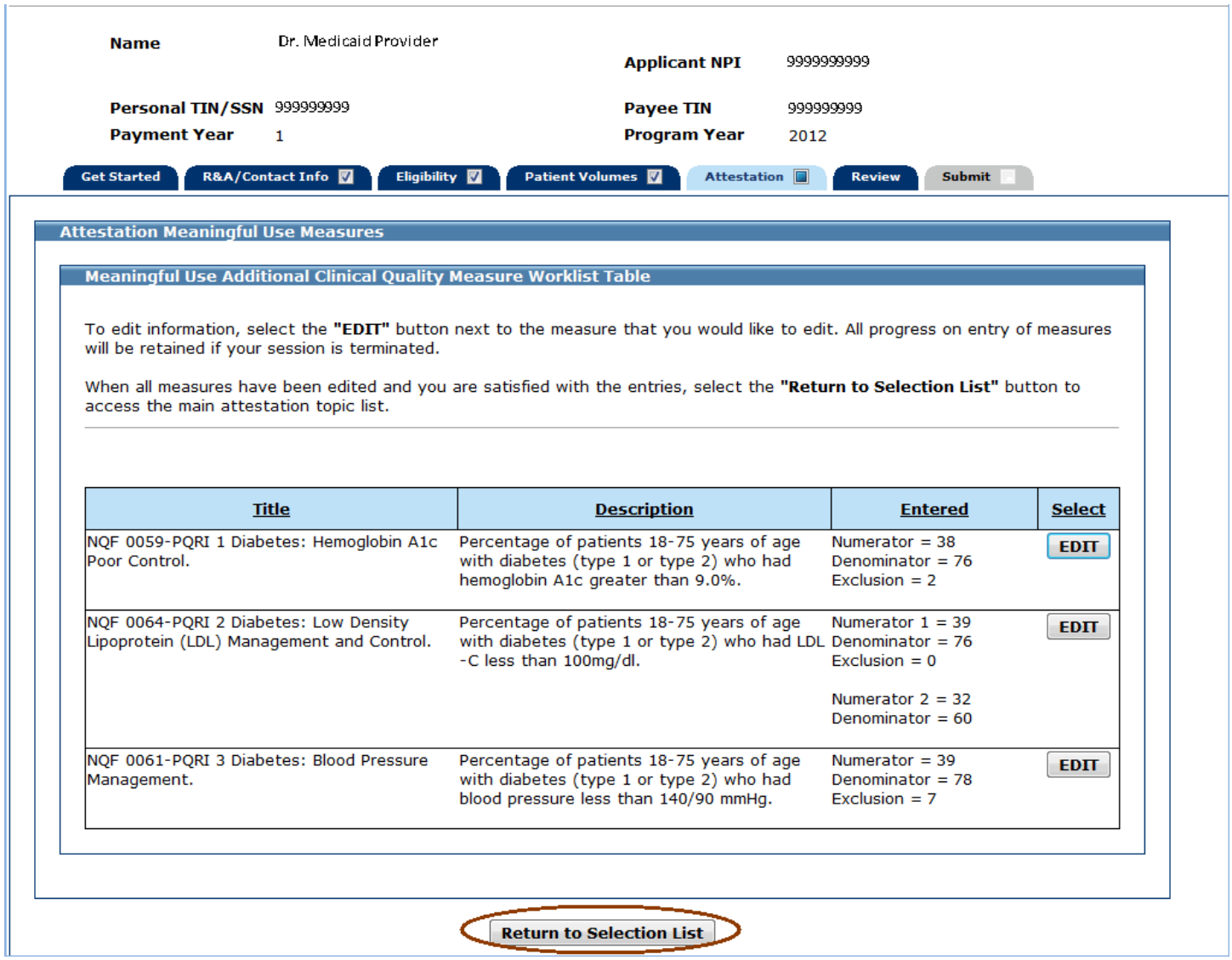
Screen 4

The following Additional Clinical Quality Measures use this screen layout:

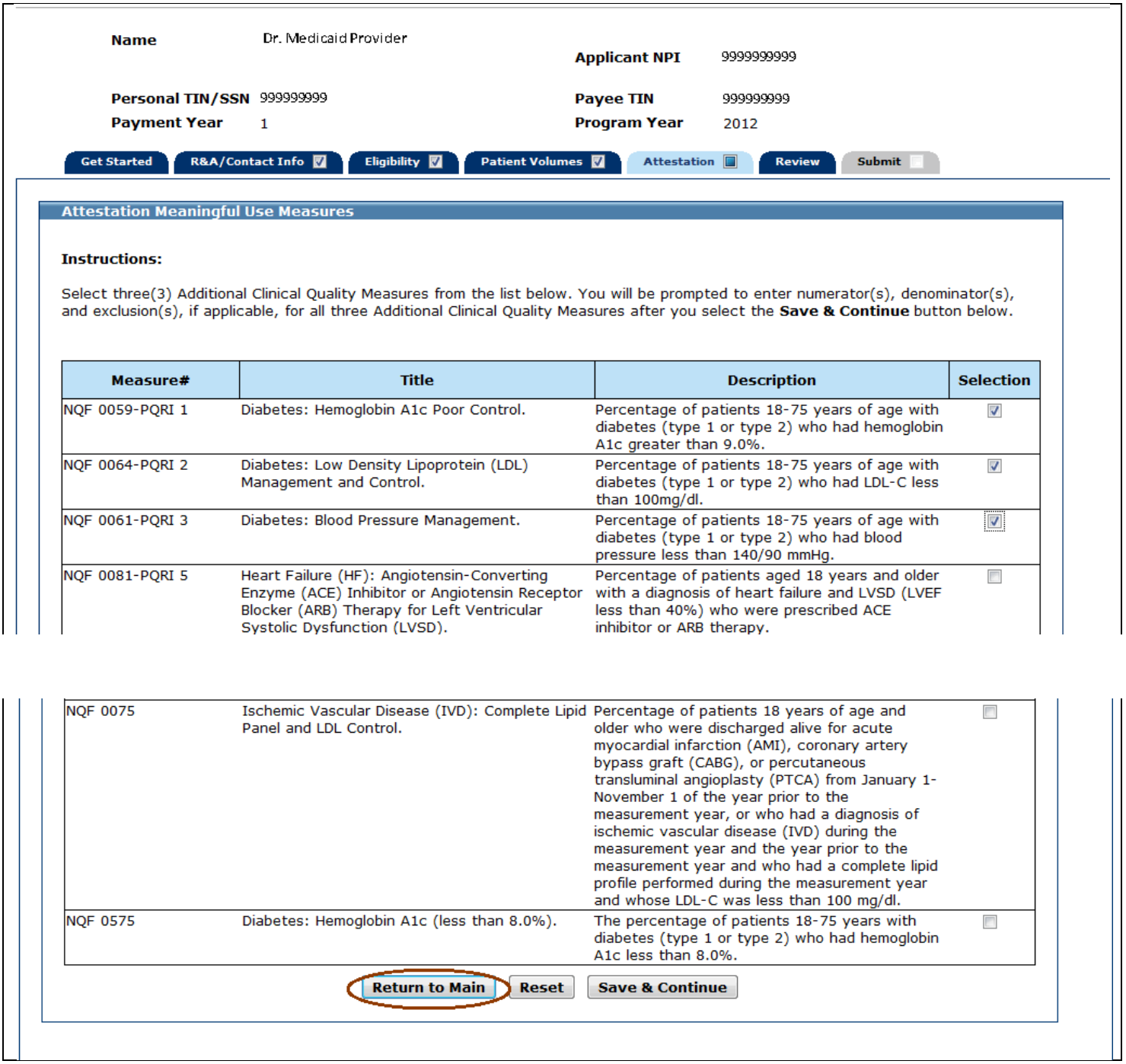
Additional Clinical Quality Measures NQF 0004, NQF 0033, and NQF 0036.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Additional Clinical Quality Measure
Click HERE for additional information on completing this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
NQF 0004
Title:
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement.
Description:
Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Complete the following information. All data entered must be a positive whole number:
Population Criteria 1:
* Numerator 1 : 24
* Denominator : 65
* Numerator 2 : 23
* Denominator : 65
Population Criteria 2:
* Numerator 1 : 29
* Denominator : 38
* Numerator 2 : 25
* Denominator : 38
Population Criteria 3:
* Numerator 1 : 40
* Denominator : 47
* Numerator 2 : 20
* Denominator : 47
Previous
Reset
Save & Continue

Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.


Name
Dr. Medicaid Provider
Applicant NPI
9999999999
Personal TIN/SSN
999999999
Payee TIN
999999999
Payment Year
1
Program Year
2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Additional Clinical Quality Measure Worklist Table
To edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return to Selection List" button to access the main attestation topic list.
Title
Description
Entered
Select
NQF 0059-PQRI 1 Diabetes: Hemoglobin A1c Poor Control.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.
Numerator = 38
Denominator = 76
Exclusion = 2
EDIT
NQF 0064-PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL -C less than 100mg/dl.
Numerator 1 = 39
Denominator = 76
Exclusion = 0
Numerator 2 = 32
Denominator = 60
EDIT
NQF 0061-PQRI 3 Diabetes: Blood Pressure Management.
Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.
Numerator = 39
Denominator = 78
Exclusion = 7
EDIT
Return to Selection List

Click **Return to Main** to return to the Measure Topic List. (Only the top and bottom sections of the Meaningful Use Additional Clinical Quality Measures Selection screen are displayed below.)



Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2012

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Attestation Meaningful Use Measures

Instructions:

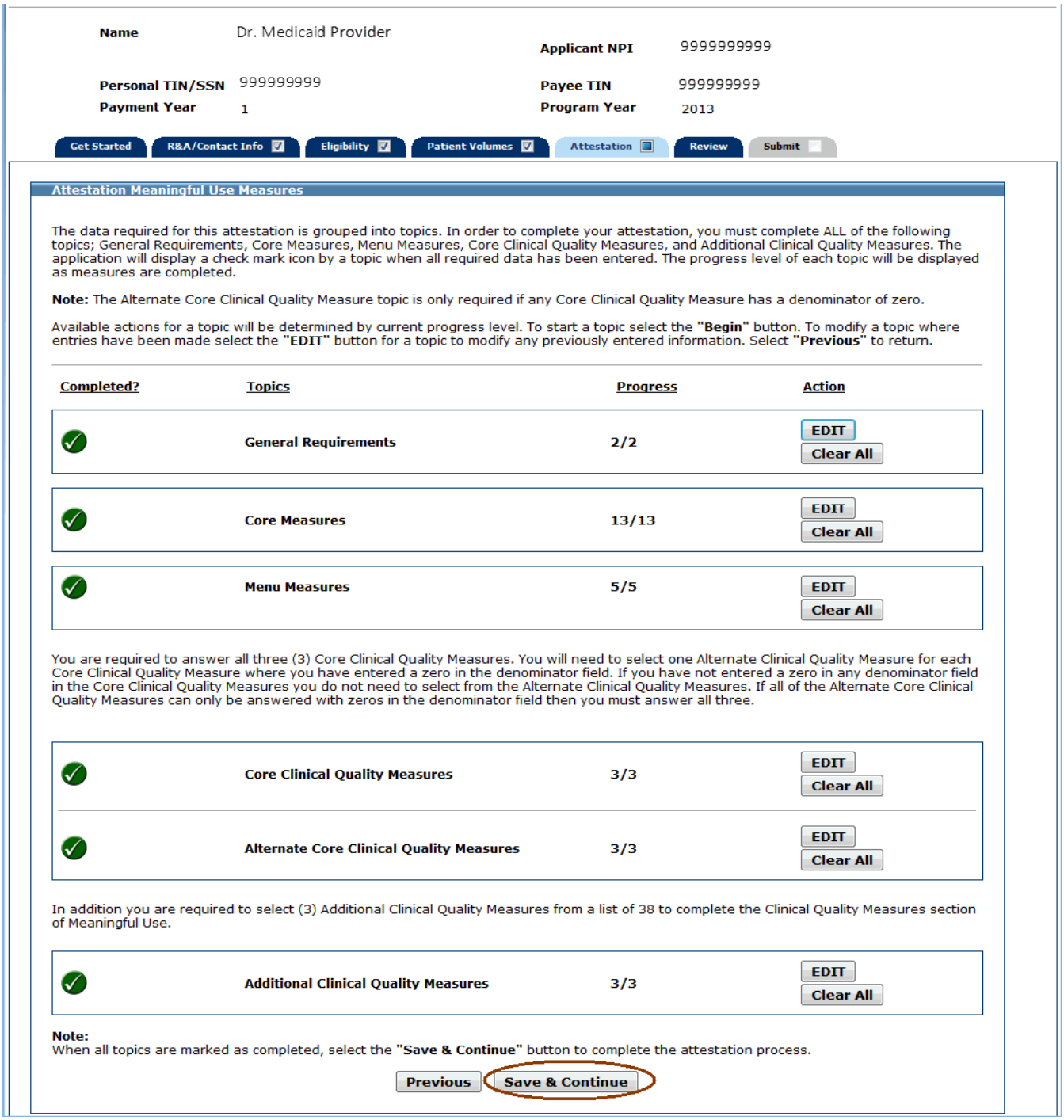
Select three(3) Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the **Save & Continue** button below.

Measure#	Title	Description	Selection
NQF 0059-PQRI 1	Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.	☑
NQF 0064-PQRI 2	Diabetes: Low Density Lipoprotein (LDL) Management and Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.	☑
NQF 0061-PQRI 3	Diabetes: Blood Pressure Management.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.	☑
NQF 0081-PQRI 5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF less than 40%) who were prescribed ACE inhibitor or ARB therapy.	☐
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was less than 100 mg/dl.	☐
NQF 0575	Diabetes: Hemoglobin A1c (less than 8.0%).	The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%.	☐

Return to Main | Reset | Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

The screen on the following page displays the Measures Topic List with all six meaningful use measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.



Name Dr. Medicaid Provider
Applicant NPI 9999999999
Personal TIN/SSN 999999999
Payee TIN 999999999
Payment Year 1
Program Year 2013

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Attestation Meaningful Use Measures

The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics; General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, and Additional Clinical Quality Measures. The application will display a check mark icon by a topic when all required data has been entered. The progress level of each topic will be displayed as measures are completed.

Note: The Alternate Core Clinical Quality Measure topic is only required if any Core Clinical Quality Measure has a denominator of zero.

Available actions for a topic will be determined by current progress level. To start a topic select the **"Begin"** button. To modify a topic where entries have been made select the **"EDIT"** button for a topic to modify any previously entered information. Select **"Previous"** to return.

Completed?	Topics	Progress	Action
✓	General Requirements	2/2	EDIT / Clear All
✓	Core Measures	13/13	EDIT / Clear All
✓	Menu Measures	5/5	EDIT / Clear All

You are required to answer all three (3) Core Clinical Quality Measures. You will need to select one Alternate Clinical Quality Measure for each Core Clinical Quality Measure where you have entered a zero in the denominator field. If you have not entered a zero in any denominator field in the Core Clinical Quality Measures you do not need to select from the Alternate Clinical Quality Measures. If all of the Alternate Core Clinical Quality Measures can only be answered with zeros in the denominator field then you must answer all three.

✓	Core Clinical Quality Measures	3/3	EDIT / Clear All
✓	Alternate Core Clinical Quality Measures	3/3	EDIT / Clear All

In addition you are required to select (3) Additional Clinical Quality Measures from a list of 38 to complete the Clinical Quality Measures section of Meaningful Use.

✓	Additional Clinical Quality Measures	3/3	EDIT / Clear All

Note:
When all topics are marked as completed, select the **"Save & Continue"** button to complete the attestation process.

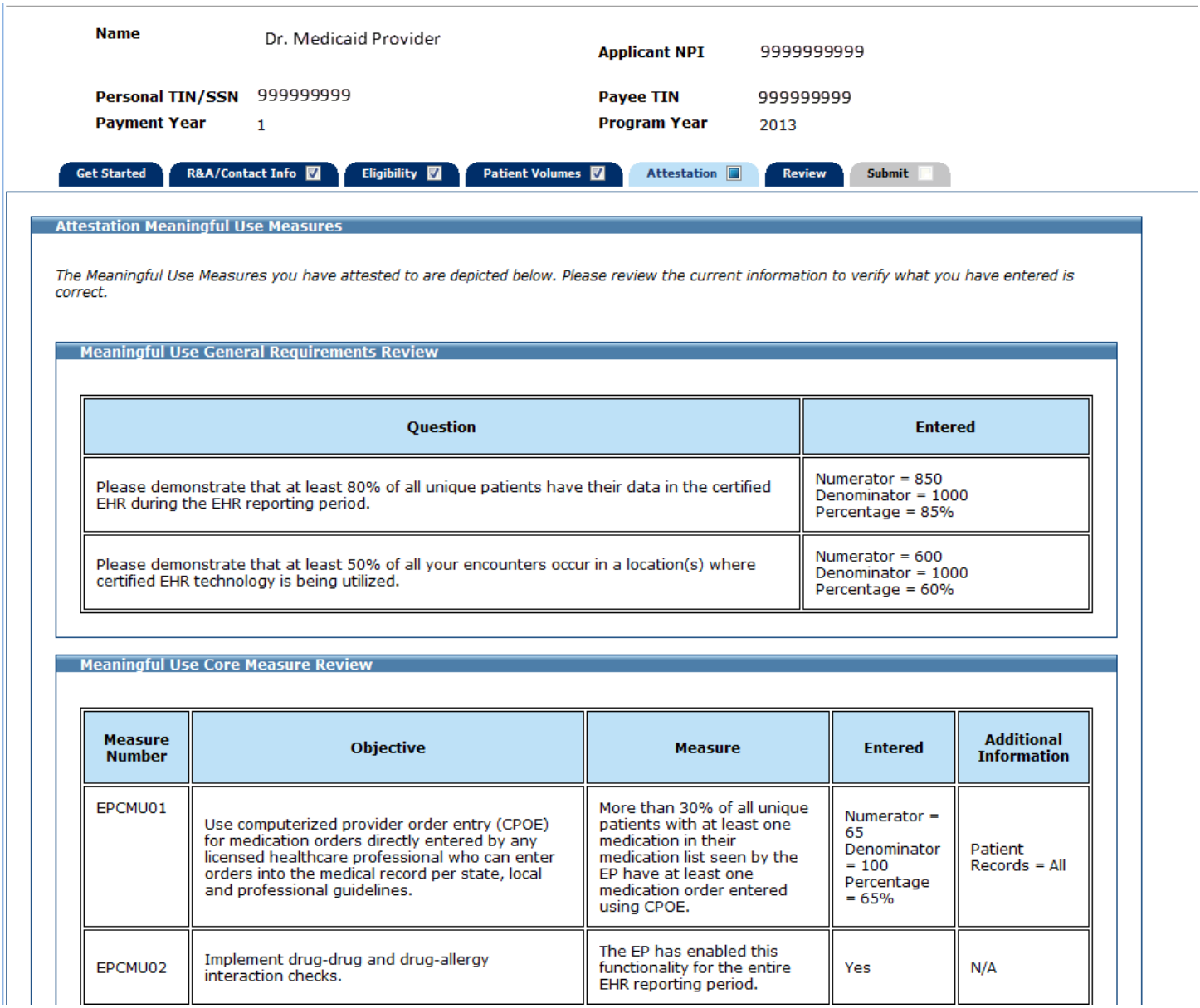
Previous | Save & Continue

Meaningful Use Measures Summary

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click **Previous** to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click **Save & Continue** to proceed to Part 3 of 3 of the Attestation Phase.



Name Dr. Medicaid Provider **Applicant NPI** 9999999999

Personal TIN/SSN 999999999 **Payee TIN** 999999999

Payment Year 1 **Program Year** 2013

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Attestation Meaningful Use Measures

The Meaningful Use Measures you have attested to are depicted below. Please review the current information to verify what you have entered is correct.

Meaningful Use General Requirements Review

Question	Entered
Please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.	Numerator = 850 Denominator = 1000 Percentage = 85%
Please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized.	Numerator = 600 Denominator = 1000 Percentage = 60%

Meaningful Use Core Measure Review

Measure Number	Objective	Measure	Entered	Additional Information
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Numerator = 65 Denominator = 100 Percentage = 65%	Patient Records = All
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	Yes	N/A

This is screen 2 of 5 of the Meaningful Use Measures Summary.

EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator = 135 Denominator = 150 Percentage = 90%	N/A
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Excluded	Patient Records = All
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator = 85 Denominator = 100 Percentage = 85%	N/A
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator = 185 Denominator = 220 Percentage = 84%	N/A
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	Numerator = 51 Denominator = 89 Percentage = 57%	N/A
EPCMU08	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children, including BMI.	More than 50% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.	Numerator = 89 Denominator = 130 Percentage = 68%	Patient Records = All
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Numerator = 45 Denominator = 81 Percentage = 55%	Patient Records = Only EHR
EPCMU11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.	Yes	N/A
EPCMU12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.	Numerator = 61 Denominator = 105 Percentage = 58%	Patient Records = All
EPCMU13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Excluded	Patient Records = All
EPCMU15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	N/A

This is screen 3 of 5 of the Meaningful Use Measures Summary.

Meaningful Use Menu Measure Review

Measure Number	Objective	Measure	Entered	Additional Information
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	N/A
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes	Patient Records = Only EHR
EPMMU06	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.	Numerator = 21 Denominator = 122 Percentage = 17%	N/A
EPMMU08	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	Numerator = 93 Denominator = 153 Percentage = 60%	Patient Records = All
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	Yes	See below for additional information

Additional Information

EPMMU09
Immunization Registry : Immunization Reg
Test Successful : Yes
Test Date & Time : 12/15/12 12:15 PM
Follow Up Submission : No

Meaningful Use Core Clinical Quality Measure Review

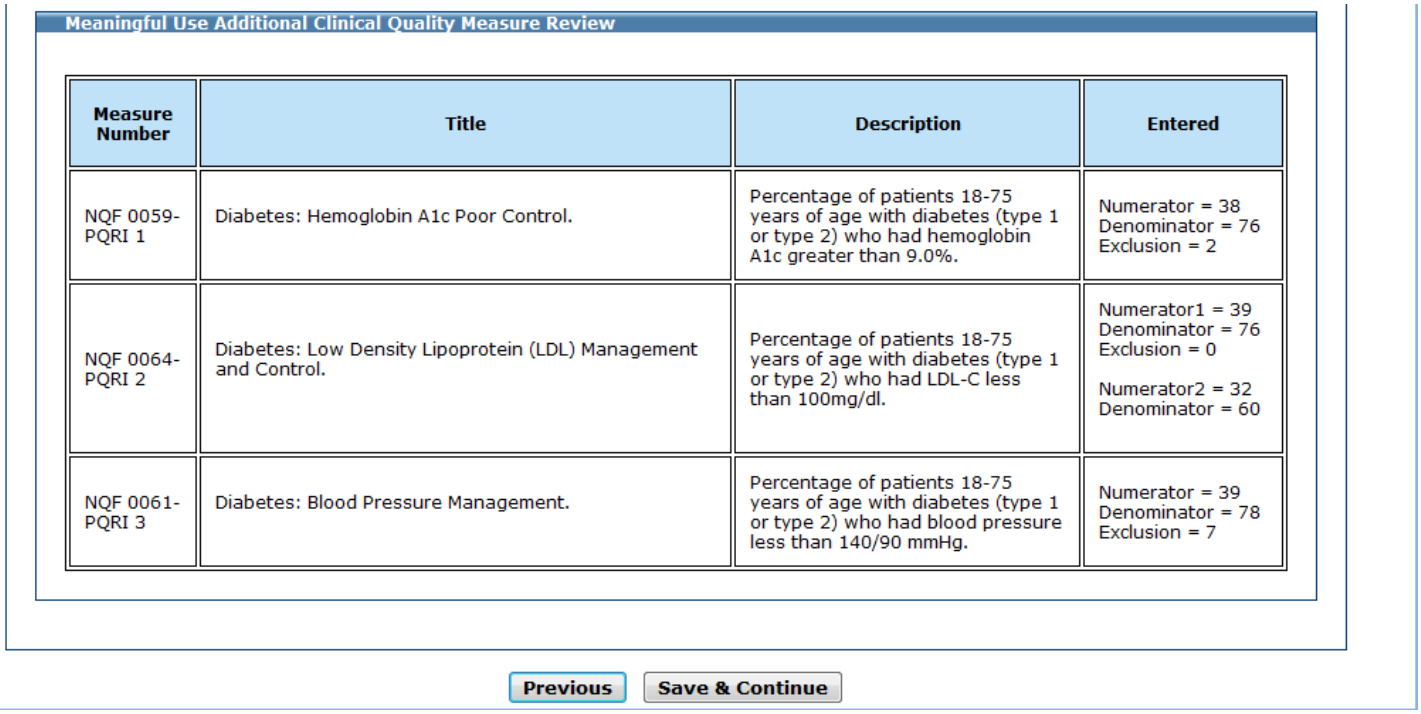
Measure Number	Title	Description	Entered
NQF 0013	Hypertension: Blood Pressure Measurement.	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.	Numerator = 55 Denominator = 100
NQF 0028-PQRI 114	Preventive Care and Screening Measure Pair.	a. Tobacco Use Assessment Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. b. Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	a.Numerator = 16 Denominator = 32 b.Numerator = 8 Denominator = 16
NQF 0421-PQRI 128	Adult Weight Screening and Follow-up.	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	**Population Criteria 1** Numerator = 35 Denominator = 80 Exclusion = 10 **Population Criteria 2** Numerator = 20 Denominator = 0 Exclusion = 5

This is screen 4 of 5 of the Meaningful Use Measures Summary.

Meaningful Use Alternate Clinical Quality Measure Review

Measure Number	Title	Description	Entered
NQF 0024	Weight Assessment and Counseling for Children and Adolescents.	Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	**Population Criteria 1** Numerator = 50 Denominator = 100 Numerator = 74 Denominator = 100 Numerator = 24 Denominator = 100 **Population Criteria 2** Numerator = 45 Denominator = 100 Numerator = 125 Denominator = 200 Numerator = 156 Denominator = 200 **Population Criteria 3** Numerator = 178 Denominator = 200 Numerator = 167 Denominator = 200 Numerator = 87 Denominator = 100
NQF 0041-PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	Numerator = 86 Denominator = 100 Exclusion = 24
NQF 0038	Childhood Immunization Status.	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HIB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	Numerator 1 = 25 Denominator = 100 Numerator 2 = 35 Denominator = 100 Numerator 3 = 45 Denominator = 100 Numerator 4 = 55 Denominator = 100 Numerator 5 = 65 Denominator = 100 Numerator 6 = 75 Denominator = 100 Numerator 7 = 85 Denominator = 100 Numerator 8 = 95 Denominator = 100 Numerator 9 = 90 Denominator = 100 Numerator 10 = 80 Denominator = 100 Numerator 11 = 70 Denominator = 100 Numerator 12 = 75 Denominator = 100

This is screen 5 of 5 of the Meaningful Use Measures Summary.



Meaningful Use Additional Clinical Quality Measure Review

Measure Number	Title	Description	Entered
NQF 0059-PQRI 1	Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.	Numerator = 38 Denominator = 76 Exclusion = 2
NQF 0064-PQRI 2	Diabetes: Low Density Lipoprotein (LDL) Management and Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100mg/dl.	Numerator1 = 39 Denominator = 76 Exclusion = 0 Numerator2 = 32 Denominator = 60
NQF 0061-PQRI 3	Diabetes: Blood Pressure Management.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.	Numerator = 39 Denominator = 78 Exclusion = 7

Previous Save & Continue

Proceed to the Attestation Phase Part 3 of 3 screen on page 171 of this guide.